THE UNIVERSITY *of* EDINBURGH

Title	Housing and Health: a geography of welfare restructuring
Author	Easterlow, Donna
Qualification	PhD
Year	1998

Housing and Health: A Geography of Welfare Restructuring

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PhD
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1998

Declaration

I, Donna Easterlow, hereby declare that the work contained herein is my own and has not previously been presented for examination.

Donna Easterlow
May 1998

Acknowledgements

I would like to thank my supervisors, Professor Susan Smith and Professor Moira Munro for all their help. Without Professor Smith's unfailing enthusiasm, encouragement and advice I couldn't and wouldn't have done this PhD. Thanks also to Professor Mike Summerfield for his support since I first arrived at Edinburgh.

Finally, I would like to thank my mum and dad, Dean and Alec for their continued faith, support and love for the past three and a half years and much longer. This is for you.

Contents

Abstract

Current health policy in England emphasises the environmental determinants of health and well-being and the care of chronically sick and vulnerable people in and by the community. A recent resurgence of research interest into the complex links between housing and health provides evidence of the detrimental effect of poor housing design, condition and location on occupants' physical health and mental well-being as well as on their access to care and social support. A new, less documented, line of research argues that the observed relationship between housing and health might also reflect the effect of health status on opportunities in the housing system. In this light it is argued here that the success of national health policy depends both on the availability of 'healthy' homes and on the effective use of housing provision to meet health and care needs.

Historically, the only part of the housing system that has actively attempted to operationalise the concept of housing for health has been the social - largely council - rented sector. For the past 25 years this has been achieved through the mechanism of medical priority for rehousing (MPR) - the process of assigning priority in the housing queues on the grounds of medical need. There is evidence, however, that just as health gain has become a legitimate objective for housing policy and practice, the system of medical priority rehousing is under increasing pressure in many areas of the country. The most important challenge comes from the privatisation of the social housing system and its changed character, size and quality, as well as its spatial unevenness. In order to explore the current capacity and future potential of a restructured social housing system to secure health gains through housing interventions, this study includes the ESRC-funded secondary analysis of data collected in the early 1990s as part of a national study into social housing provision for people with health and mobility needs in England.

My analysis highlights geographical differences in the operation of medical rehousing and documents the inequitable outcomes that occur both within and between local areas as housing managers implement a range of different rationing methods in the attempt to regulate demand for rehousing. Complementing a large existing literature on the problems of access to council housing for the most marginalised groups in society, I explore the difficulties experienced by those with health needs - a relatively privileged group among the benefit-dependent poor - in mobilising the system of medical priority rehousing and of securing a suitable home through the process of matching applicants to stock.

While on the one hand the study shows that medical priority rehousing can secure favourable housing (and health) outcomes for some of those with health needs, an important point to emerge is that the system is increasingly failing to cater for the majority of those in medical need, albeit more so in some areas than others, in most parts of the country. This raises important questions - that are also briefly explored - about how those with health problems fare in the market sector of the housing system. I conclude that, in order to harness housing policy and practice to health aims more effectively, a more tenure-neutral healthy housing policy is required. Thus my recommendations include a number of administrative changes to the operation of medical priority rehousing as well as an increased social investment in all housing sectors.

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HOUSING AND HEALTH: AN OVERVIEW

1.1 Introduction

Recent years have seen a welcome re-awakening of the nineteenth century interest in the relationship between housing and health. Now, as then, the main approach has hinged on exploring and documenting the causal influence of poor housing on occupants' health. The results of this research suggest that while many of the traditional home-based health hazards have been eliminated, others remain and still other, new ones, have emerged.

The focus of this thesis moves a step beyond this knowledge base. Its main line of argument is that if poor housing can impair people's experience of health and well-being, it might also be the case that the converse is true. Good housing may have the potential to enhance health and well-being. For sick people, for instance, good housing may assume a therapeutic and/or palliative role. Housing provision may, therefore, represent an effective instrument of health and social care. What this means is that whereas in the nineteenth century housing interventions were seen as an appropriate element of health policy, today health gains and the provision of health care might be regarded as a legitimate objective for housing policy and the housing system.

To set the scene for the present research, this introductory chapter looks first at the evidence linking housing conditions to occupants' health. Before suggesting that good housing might promote health, how sure are we that poor housing is hazardous to health? Having laid out the evidence linking housing causally to health, the chapter goes on to consider the converse: to what extent might housing interventions be employed to secure health gains for the sick. An important determinant of this is the

access of people with health problems to good quality, suitable accommodation. The possibility that poor health affects housing opportunities will also, therefore, be introduced. Next the chapter lays out the policy context in which these different links between housing and health have been recognised in the past and are set today. Finally, I provide an overview of the main arguments in this thesis, indicating how they are dealt with on a chapter by chapter basis.

1.2 The housing determinants of ill-health

To the Victorians, the causal links between health and housing conditions were obvious and indisputable (Smith 1989a). A doubling of the population of England and Wales between 1801 and 1851 coupled with high rates of urbanisation, led to massive housing problems as the new labouring classes were forced into overcrowded and substandard accommodation. It was at this time that the word 'slum' first entered the English language to describe these atrocious living conditions (Bynum 1991). Reformers and philanthropists, including Edwin Chadwick and Friedrich Engels, were able to document large variations in life expectancy and disease incidence between those living in the slums and those residing in the more spacious suburban housing on the outskirts of the cities and towns (Jacobs & Stevenson 1981; Smith 1989a; Bynum 1991). At that time diseases were thought to be caused and transmitted by the miasma or noxious gases found in slum areas. Although mistaken in its reasoning, this 'theory' did make an association between housing and the living environment and health, and, because it implied that the problem could spread to more affluent areas, it lead to action that was beneficial (Byrne *et al.* 1986; Ormandy 1987; Lowry 1991). Slum clearance, rubbish collection, drainage facilities and ventilation for houses did improve living standards and health.

Links between housing and health continue to exist today. The evidence reviewed later in this section is testimony to the fact that poor housing and poor health still, somehow, go hand in hand, suggesting perhaps that we might also be able to associate good housing with good health. But despite this renewed interest in the association between housing environments and health which has been described as 'essentially self-evident' (Mant 1993, p.3), and despite the ease with which researchers have been able to document statistical associations between indicators of housing conditions and of health at both the individual and community level, a number of problems in establishing causality have been encountered. Notwithstanding the possibility that the

link is not direct afterall, the continuing existence of a relationship between housing and health as observed and believed in by many researchers and occupants of poor housing, suggests that it should continue to be explored but perhaps a little more imaginatively than has hitherto been the case.

Hunt (1993) argues that until recently, research concerned with the links between housing and health has been conducted and largely interpreted according to a 'medical model' of disease, emphasising individual pathology, individual diagnosis and individual treatment. According to this model, physical disease results from specific pathological processes in the biochemical functions of the body and each is caused through a specific pathogenic agent, micro-organism, or disease vector. Similarly there is presumed to be something in the biology of the individual that predisposes him or her to mental disorder (Jones & Moon 1987). These causes are to be established by traditional (positivist) 'scientific' investigation, in the laboratory if possible.

While in some instances specific pathogens, present in some dwellings, have been identified, linking particular aspects of housing, particularly cold, damp and mould, via very plausible biomedical causal processes, often they have not. Laboratory and other studies have failed to demonstrate clear causal relationships in the positivist sense. In particular, identifying causal mechanisms to account for the impact of the built environment on mental health has proved difficult.

Greater understanding of the relationship between housing and health may also be limited by the 'technical fragmentation' (Hunt 1993) of the research effort. Environmental Health Officers, doctors, academic researchers and housing occupants, all with an interest in the topic and with important contributions to make, have tended to work independently of one another. A co-ordinated cross-disciplinary, cross-profession research effort in which 'experts' pool their findings and work together, has therefore been called for (Ormandy 1987; Smith 1989a; Hunt 1993; Mant 1993).

Some commentators have therefore questioned 'the extent to which we should insist on hard 'scientific' evidence, rather than sensible observation' (Lowry 1991, p. 13), in order to assert that there is a link between poor housing and ill-health and to formulate policies to deal with it (Byrne & Keithley 1993). In the nineteenth century effective action on the housing and health front, as we saw above, was not predicated on a correct understanding of the causal mechanisms. This 'scientific' approach, moreover, distracts attention from the wider variety of ways in which housing can

affect, positively as well as negatively, people's experience of health, sense of well-being and quality of life. The observed relationship between housing and health, particularly mental health, may be much more complex than that allowed for by the medical model.

We know, for instance, that where you live – in what housing and neighbourhood – is an important indicator of your income and social class. What this means is that poor housing is just one factor in a web of interacting variables or a 'causal system' (Byrne & Keithley 1993) that constitute deprivation and influence health, and are themselves likely to covary with housing. These include low income, environmental pollution, smoking, poor nutrition, unemployment and stressful life events among others (Smith 1989a; Freeman 1993). For those carrying out research in the 'scientific' tradition it is necessary to pin point contributory housing factors. Failure to do so might imply that it is other factors related to poverty – such as an increased propensity to smoke or consume fatty foods for instance – that *can* be implicated in the aetiology by scientific methods, that explains the observed relationship.

It may, however, be impossible, indeed undesirable, to disentangle the effects of these factors individually since to do so would be to ignore the effect of these interactions and perhaps to underestimate the importance of housing (Byrne & Keithley 1993; Mant 1993; Thunhurst 1993). For instance, health-threatening behaviour such as smoking might be employed by those living in poor housing conditions as a means of coping with their depressing living environment (Ambrose 1997). The complexity of the issue may, however, diffuse pressure for (housing) policy initiatives to address the issue (Hopton 1993; Hopton & Hunt 1996a, 1996b Thunhurst 1993).

It might similarly be the case that the housing environment predisposes some individuals to particular diseases, rather than 'causes' them in the pathogenic sense. Put another way, good housing may have a protective effect and be important in reducing susceptibility to ill-health. The 'general susceptibility' model may provide an alternative approach to understanding the relationship between poor housing and physical disease (Ambrose 1997; Hunt 1993; Hopton & Hunt 1996a). For instance, poor housing conditions might not only encourage the spread and survival of particular pathogens, but the strain and discomfort of living in a home in poor condition or that is cold or damp, for instance, may make the inhabitants more vulnerable to its effects (Hunt 1993). Distress and anxiety associated with housing

circumstances may also precipitate a range of physical diseases or psychosomatic illnesses (Kellet 1989).

Research is beginning to document the general psycho-social implications of occupying a marginal position in the housing system. Kearns *et al.* (1992) have explored, for instance, the adverse health effects associated with the stress of 'incipient homelessness'. More recently, Burrows (1998) and Nettleton (1998) have argued that the financial stress associated with marginal home ownership represents an important public health issue. Expanding on Wilkinson's (1996) argument that the psycho-social impact of relative deprivation may have health consequences reaching beyond those of particular environmental hazards, they have found that the stress associated with mortgage arrears and the threat of repossession undermines householder's health and increases their demands on the health services (Nettleton & Burrows, in press).

Notwithstanding the problems encountered by researchers in specifying causal links between the housing environment and occupants' health, they have succeeded in building up a wealth of evidence to suggest that a relationship continues to exist today, and is experienced by large numbers of people, in some form. The research effort has implicated a range of housing characteristics, including the fabric, design and construction of housing, its condition, occupancy and location, together with the effects of moving home, on the state of physical and/or mental health (Smith 1989a; WHO 1989). Some of the evidence for both the direct and indirect (psycho-social) impacts of housing on health will be reviewed here, and is summarised in Table 1.1, together with a discussion of what the findings might suggest about the nature of this relationship. This particular approach to exploring the relationship between housing and health does not represent a central theme of this thesis. However, if the argument of the thesis – that good housing might be able to promote good health – is predicated on the assumption that poor housing can lead to poor health, it is important to establish just how sure we are that poor housing is in fact detrimental to occupants' health.

1.2.1 Housing fabric, design and construction

The fabric, design and construction of the home may represent, it has been suggested, a number of health hazards. Asbestos and foam insulation have been linked with lung cancer; wood preservatives and pesticides (used to protect against woodworm and dry

Table 1.1 The housing determinants of ill-health: summary of the research effort

Housing characteristic	Research study	Associated health problem
Design, fabric and construction		
Stairs, steps, glass windows, slippery floors, fireplaces.	Ranson 1993.	Accidents, especially falls & fires, particulary among children and older people.
High-rise housing	Bagley 1973; Fanning 1967; Freeman 1993; Gilloran 1968; Hannay 1981; Littlewood & Tinker 1981; Moore 1974, 1975, 1976; Stewart 1970.	Psychiatric disorder, stress, depression, isolation, fear of crime, especially among women with young children.
Condition		
Damp and mouldy homes	Brunekeef 1989; Dales *et al.* 1991; Hopton & Hunt 1996; Hunt 1990; Hyndman 1990; Martin *et al.* 1987; Packer *et al.* 1994; Spengler *et al.* 1993; Strachan 1988; Strachan & Elton 1986; Strachan & Saunders 1989.	Coughs, wheeze, sore throats, diarrhoea, vomiting, tiredness, & headaches among children. Nausea, vomiting, constipation, breathlessness, backache, aching joints, fainting, bad nerves & stress among adults.
Cold homes	Collins 1993; Collins *et al.* 1985; Keatinge *et al.* 1984.	Hypothermia, coronary & cerebral thrombosis & respiratory disease, particularly among older people.
Occupation		
Overcowding	Barker & Osmond 1987; Britten *et al.* 1987; Conway 1993; Duvall & Booth 1978; Gabe & Williams 1986 1987, 1993; Gove *et al.* 1979; Gove & Hughes 1983.	Overcrowding making hygiene & sanitation difficult linked to diarrhoea, sickness, coughs, cold chest infections among children. Overcrowded living conditions in childhood linked with chronic bronchitis, heart disease & stroke in adulthood. Psychiatric illness, nervous breakdown, particularly among women.
Residential location		
Difficult-to-let (council) estates	Byrne *et al.* 1986; Blackman *et al.* 1989.	Respiratory disease, psychological stress.
Location	Macintyre *et al.* 1993; Sooman *et al.* 1993; Tudor-Hart 1971.	Access to sports facilities & 'healthy' foods, & opportunity therefore to follow a 'healthy' lifestyle. Access to formal & informal health and social care.
Moving home	Brett 1980; Dimond *et al.* 1987; Kasl 1984; Rowland 1977; Stokols & Shumaker 1982.	Cause or exacerbate mental illness. Particularly stressful for women and older people.
	Clark & Cadwallader 1973; Elton & Packer 1986, 1987; Deane 1990; Stokols *et al.* 1983.	Reduces stress and improves health & well-being when move is from home in poor condition.
	Litwak & Longino 1987; Meyer & Cromley 1989.	Improves access to formal & informal health and social care.

rot) may cause respiratory and skin problems (Conway 1995; Lowry 1991; Smith 1989a). Building materials and construction methods may also have important implications for the condition of the home (considered next) and might, therefore, have a range of indirect health effects. Dwelling design and construction faults, in particular the provision of inadequate waste disposal systems, have also been implicated in rat and cockroach infestation. These pests are dangerous carriers of food-poisoning and other disease-causing organisms (Howard 1993).

The current health Green Paper in England *Our Healthier Nation* (Secretary of State for Health 1998) identifies accidents as one key area in which substantial improvements in the nation's health must be achieved. Accidents are a major cause of death, illness and disability. Over 3.2 million accidents occur in the home in the UK each year, approximately 5,000 of these being fatal. This represents 40% of all fatal accidents and a third of all accidents treated in hospital (Ranson 1993). The main causes of home accidents are falls (60%) and fires (15%) (Arblaster & Hawtin 1993). The young, the old and the poor, especially homeless families living in temporary accommodation, are most at risk. Around three-quarters of a million children under the age of sixteen are injured in or around the home each year, and about 5,000 of these are permanently disabled (Arblaster & Hawtin 1993; Ranson 1993). Older people suffer fewer home-related accidents, but more of these cause serious injury or fatality. Falls are the most important domestic accident and their incidence increases with age (Luukinen *et al.* 1996).

The design and construction of the home have been linked to many of these accidents: those associated with, though not necessarily caused by, design, constructional and architectural features, including stairs, steps, slippery or uneven floors, glass windows and doors and fireplaces among others, account for the majority of all accidents in the home (Ineichen 1993; Ranson 1993). In 1988, for instance, 27,000 accidents in the UK were attributable to non-safety glass in doors and windows (Arblaster & Hawtin 1993). High-rise dwellings are linked with an increased risk of accidents, particularly among children, due to the dangers of falling from open windows, balconies and problems of supervision of children playing outside. The number of house fires has been rising in recent years (Roberts 1995). Domestic fires account for less than one-fifth of all fires, but cause three quarters of all fatalities (Acheson 1991). Fire can spread rapidly through tower blocks especially along ducts which run through them (Lowry 1991; Freeman 1993).

Perhaps the aspect of housing design to have received most attention over the years in relation to its effect on health, particularly mental health, is that of (largely council) high-rise housing, built in the 1960s and early 1970s. Freeman (1993) and Ineichen (1993) provide excellent reviews of the research that has been carried out on the subject. The literature may be quite dated, but its findings remain significant, particularly to local housing authorities, whose tenants have become increasingly concentrated in flatted accommodation in recent decades.

Freeman (1993) has linked the unpopularity of (some) tower blocks among the working class populations housed in them in England, to a cultural tradition of houses, rather than flats, as the accommodation norm and to which most people aspire. Much of the bad reputation of high-rise housing, however, also stems from its design, construction and maintenance problems. Poor quality concrete allows water penetration, asbestos has been used widely for insulation, heating systems are problematic, rubbish disposal systems are inadequate, and lifts are lifts often broken down (Lowry 1991). The damp, mouldy and cold conditions that often resulted from this and their effects on physical health will be described next, but much interest in high-rise housing has also concentrated on its effect on mental health.

A number of studies have found a positive association between high-rise living, particularly for mothers with young children, and poor mental health. These include those conducted by Bagley 1973, Fanning 1967, Gilloran 1968, Hannay 1981, Littlewood & Tinker 1981 and Stewart 1970. Other studies, however, have failed to discover a link. Ineichen and Hooper (1974) and Hooper and Ineichen (1979) found greater incidence of neurotic symptoms amongst women living in houses rather than high-rise flats, and McCarthy *et al.* (1985) and Byrne *et al.* (1986) found that, although high-rise flats located in 'difficult to let' areas were associated with high levels of psychological distress, similar dwellings in 'good' areas were not. They concluded that the type of area rather than the type of housing in which people live, is more important in causing psychological distress (see also later). In a series of studies, Moore (1974, 1975, 1976) failed to find a significantly increased prevalence of psychiatric disorder amongst the women living in a tower block. What he did conclude, however, was that living in high-rise flats, but not houses, is likely to contribute to people with neurotic personalities developing psychiatric illness.

Fear of crime has been suggested as one explanation for the raised incidence of stress among high-rise flat-dwellers, though again this might relate to their location in poor,

crime-ridden areas. Stairways are usually invisible from nearby roads and houses and the worry to old people and women in particular of attack is common (Lowry 1991). Freeman (1993) has also argued that the immediate environment of the tower block may be detrimental to mental health. Litter (often because rubbish collection services are inadequate), graffiti, and vandalism in blocks of flats are common, especially in the common areas such as the stairwells, lifts and entrances.

A number of studies have investigated the way in which different environmental forms can influence the extent to which social support is received. It seems that those living in high-rise dwellings may, on the whole, receive less support than those in other dwelling types because of the reduced ease of access and opportunities for informal encounters (Freeman 1993). This may be associated with higher rates of depression in particular. Gilloran (1968) concluded from a study in Edinburgh that the outstanding problem of family life in high-rise flats, especially among young mothers, was isolation. This was usually a result of having been separated from relatives and established friendship networks in moving to their current homes. Richman (1974) compared families living in council rented high-rise flats, low-rise flats and houses, in the same London borough. She found that mothers looking after young children were particularly at risk from depression. She argues that since contact with neighbours might only be by chance, when entering or leaving the flat, flat-life seemed to exacerbate the problems of women who were poor mixers and to increase the problems of isolation and restriction to the home experienced by many mothers of young children. It is, for example, a major undertaking just to get out of the house for a couple of hours with young children and prams when the lift is out of order and the stairs must be used (Lowry 1991).

1.2.2 Dwelling condition

Probably one of the most researched areas in the field of housing and health, particularly in Britain, is that of the observed link between respiratory disease and damp, mouldy and cold housing. The English House Condition Survey (DoE 1993) found that dampness was present in 10% of occupied public sector dwellings and nearly a quarter of private sector accommodation, though it has been suggested that as much as a third of dwellings in Britain are affected by damp to some extent (Arblaster & Hawtin 1993).

Building design and construction material is often implicated in the dampness and coldness of dwellings. Precast concrete – used in the construction of much of the post-war local authority housing – for instance has a high thermal incidence and is therefore difficult to heat, and at the same time has a serious incidence of condensation (Hopton & Hunt 1996a). The pure water of condensation encourages mould growth. Ill-fitting windows and doors can also cause draughts. The fact that it is poorer households who live in such dwellings serves to compound the problem since they are less able to afford to heat them adequately.

A series of studies carried out in Edinburgh linked damp and mouldy housing conditions with self-reported respiratory disease in children. The incidence of a range of respiratory symptoms such as persistent coughs, wheeze, sore throats, (as well as non-respiratory symptoms like aches and pains, diarrhoea, vomiting, tiredness and headache) was found to be significantly higher among those children living in damp or mouldy housing than those who lived in dry housing, and on the whole this remained true after controlling for economic position, parental smoking, overcrowding and type of heating (Strachan & Elton 1986; Strachan 1988; Martin *et al.* 1987; Strachan & Saunders 1989). Strachan & Saunders (1989) found more than twice the reported incidence of wheeze and chesty coughs among those children whose bedrooms were damp than among those who were not (the differences were even greater if mould was present in addition to dampness), suggesting a dose-response effect (a finding supported by Platt *et al.* 1989). Moreover, Hopton and Hunt (1996a) have also more recently tentatively concluded from a longitudinal study in Glasgow, that the elimination of dampness and cold may have some beneficial effect on children's symptomatic health. Since these pioneering studies in Scotland, studies in the USA (Brunekeef 1989; Spengler *et al.* 1993) and Canada (Dales *et al.* 1991) have reported similar findings.

Adults living in damp and mouldy dwellings have also been found to be more likely to report symptoms of nausea, vomiting, constipation, blocked nose, breathlessness, backache, aching joints, fainting and bad nerves than those living in dry dwellings (Hyndman 1990; Packer *et al.* 1994; Platt *et al.* 1989). These differences remain after controlling for the respondent's economic position and cigarette smoking. Packer *et al.* also found a dose response relationship between self-reported damp housing and perceived long-standing illness, disease or infirmity.

A number of plausible biological explanations for these associations have been invoked. Damp housing conditions harbour several agents that may be harmful to health. Viruses which give rise to infection are more common in damp dwellings and dampness, particularly high levels of humidity, also encourages the house dust mite (Hunt 1993; Howden-Chapman *et al.* 1996). Burr *et al.* (1980, 1986) have linked house dust mites, dampness and symptoms of ill-health. House dust mite allergens, particularly faecal pellets, have been implicated in the incidence of respiratory health problems, especially wheeze, and are therefore closely linked to the risk of developing asthma (Hunt 1993; Sporik *et al.* 1990). Damp conditions, particularly the existence of condensation, are also critical for the growth of moulds and fungi. Such conditions are conducive to the germination of fungal spores and these can give rise to allergic reactions, precipitating asthma, rhinitis and alveolitis, to infections, particularly of the lungs (though this is relatively rare), and to toxic effects which can affect the immune system if present in the lungs, thereby exacerbating allergies and infections (Howden-Chapman *et al.* 1996; Hunt 1993).

Although the reality of the link has been questioned by Strachan (1993) who criticises the use of self-reported symptoms and housing conditions, a number of researchers (Howden-Chapman *et al.* 1996, Hunt 1993, Packer *et al.* 1994) have concluded that the observed associations between respiratory illness and damp and mouldy housing meet the principal criteria for the acceptance of a causal link: the associations are strong, are largely consistent across studies and cannot be accounted for by other variables such as smoking and low income, there is a biological gradient as represented by a dose-response effect, at least for some symptoms, and the findings are biologically plausible.

There is evidence, moreover, that damp housing conditions may be linked with poor mental well-being. Among the studies cited above, Martin *et al.* (1987) found a link between independently assessed dampness and emotional distress among adults and children, and Hunt (1990) reported a significant relationship between damp housing and women's scores on the general health questionnaire (GHQ) that existed independently of social class, employment status and household income. Packer *et al.* (1994) reported that people living in damp housing are significantly more likely to report problems with energy, social isolation and sleep than those in dry housing. This might not be surprising. As Lowry (1991, p. 19) points out 'the psychological consequences of having to scrape mould off the walls of your home every day are obvious'.

Coldness in the home can exacerbate the effects of damp and the two are often found together. For a given volume of moisture, lower temperatures increase the relative humidity and chances of condensation which further encourages the growth of mould and mites (Smith 1989a). But low temperatures can be directly harmful to health (Collins 1993; Khaw 1995; Markus 1993).

About 40,000 more people die in winter than in summer each year in Britain (Court 1994) – a phenomenon that is not repeated to the same extent in other European countries, even those with much colder winters, where homes are warmer and better insulated (Collins 1993). The risk of hypothermia – a fall in body temperature to below 35 degrees Celsius – especially among the elderly who are known to be particularly vulnerable to the effects of a cold home environment because of a less efficient body temperature regulating mechanism (Collins 1993) is well-known. However, only a small fraction – perhaps only 1% – of Britain's excess winter deaths are associated with hypothermia and in only half of these cases is hypothermia considered to be the underlying cause of death (Collins 1993). The vast majority of excess winter mortality is in fact the result of coronary and cerebral thrombosis and respiratory disease (Collins 1993; Smith 1989a). Respiratory problems become more common at temperatures below about 16 degrees through the impairment of the functioning of the bronchial epithelium (Collins 1993), while temperatures below about 12 degrees result in cardiovascular changes that increase the risk of myocardial infarction and stroke (Lowry 1991; Smith 1989a). It is not until temperatures fall well below 5 degrees that there appears to be a significant increase in the risk of hypothermia (Lowry 1991).

Collins *et al.* (1985) have found that cold extremities and slightly lowered core temperatures can lead to short-term increases in blood pressure. This, they conclude, can be damaging to people already suffering from hypertension, but especially older people. And further, it has been argued that raised blood pressure in the cold may have a long-term effect on the development of arterial thrombosis. Low indoor temperatures can also lead to an increase in blood platelet and red cell counts and increased blood viscosity (Keatinge *et al.* 1984), and together these factors could contribute to the increase in arterial thrombosis, particularly among older people, that is characteristic of cold conditions (Collins, 1993).

The very groups who spend most of each day at home and therefore experience its coldness most intensely, including older people and the chronically sick, as well as the

unemployed and small children, are also the groups who are the least able to afford to heat their homes (Lowry 1991). The most frequent cause of underheating relates to an 'inadequate income to meet the fuel expenditure required by the type and size of the house, its thermal properties, the type of heating system, the available fuel, the necessary use pattern and the general and microclimate conditions' (Markus 1987, p.2). The term 'fuel poverty' has been used to describe the situation whereby the people with the least to spend on heating are very often housed in the homes that are hardest to heat (Lowry 1991). Even so, it has been estimated that the poor spend twice as much as a percentage of their total income as the rest of the population on heating, despite spending less in absolute terms (Lowry 1991; Smith 1989a). Moreover, attempts to economise through heating only certain rooms can cause temperature differentials that encourage condensation and mould growth (Lowry 1991).

1.2.3 Housing occupation

A further characteristic of the home identified in the research as having important implications for both the physical and mental health of occupants, relates to their utilisation or occupancy of it. Nitrogen dioxide from gas cookers (Melia *et al.* 1979; Florey *et al.* 1979) has been linked to increased respiratory disease among children. Carbon monoxide poisoning, largely from faulty gas appliances, particularly central heating boilers, and inadequate ventilation, has received much publicity in recent years after a number of fatal cases hit the headlines. The number of deaths in Britain have fallen since the conversion from town gas to natural gas – though stands at about 100 each year – since the latter does not contain carbon monoxide. Since symptoms are often vague and non-specific, it is argued, that many cases go unrecognised (Crawford *et al.* 1990).

The role of *overcrowding* in the spread of infectious disease in the last century is, and was at the time, indisputable. Today the major causes of mortality and morbidity are no longer the infectious diseases, but cardiovascular and respiratory illnesses, and cancers (Barker 1989). Moreover, very few households experience such high living densities. The rise in the number of homeless individuals and households accommodated in cramped conditions in hostels and other temporary accommodation, often with inadequate and shared washing, toilet, food storage and cooking facilities (Conway 1993) means however that some people today live under conditions that 'are little better than in Victorian slums' (Lowry 1991, p.44). Opportunities for good

hygiene and sanitation in these conditions is extremely limited (Smith 1989a). Infectious disease continues to be higher among these overcrowded populations. Children in particular are more likely to suffer from diarrhoea and sickness and coughs and colds and chest infection (Conway 1993). A number of studies have, moreover, linked overcrowded living conditions in childhood to ill-health in later life. Pulmonary infection in childhood, associated at least in part with overcrowding, may be linked with chronic bronchitis and heart disease and stroke in adulthood (Barker & Osmond 1987). Britten *et al.*'s (1987) longitudinal study demonstrated that adult chronic cough and diminished lung function are positively associated with infant exposure to overcrowding, and particularly the associated increased risk of recurrent chest infections. The rising incidence of pulmonary tuberculosis among homeless men living in hostels and in deprived areas with high levels of overcrowding is also of increasing concern in Britain and the USA (Bhatti *et al.* 1995; Darbyshire 1995; Mangtani *et al.* 1995). High living densities and shortage of space also increase the risk of accidents, especially fire. Those living in cramped conditions in homeless hostels are particularly vulnerable, especially children (see above).

It has been suggested, however, that there is little evidence to relate overcrowding and physical disease directly, but that there may be an indirect link (Kellet 1989, 1993). The stress of living in overcrowded conditions may precipitate cardiovascular disease and it might encourage smoking which is implicated in respiratory disease and some cancers.

Indeed, the threat to health posed by living density is today perceived to be greatest in relation to mental health. The literature, however, presents an inconsistent picture. Booth and associates (Booth & Edwards 1976; Booth & Cowell 1976) found that overcrowding (measured in terms of persons per room and the amount of contact between household members) had little or no effect on mental health or family relations. Balsadarre (1979; 1981) reported that household density (persons per room) was not significantly related to satisfaction with health and life, fear of a nervous breakdown, feelings of depression or restlessness. Gove and associates (Gove *et al.* 1979; Gove & Hughes 1983), on the other hand, found that the number of persons per room was strongly associated with a number of measures of psychiatric illness, nervous breakdown and self-esteem and poor social relationships in the home. They found similar links between mental health and perceived levels of crowding (see also Duvall & Booth 1978), a finding confirmed by a study of women in London by Gabe and Williams (1986, 1987, 1993).

It appears to be women, and especially those with small children, living at high density who suffer the effects of overcrowding in the most (Brown & Harris 1978). This is hardly surprising, it has been argued, in light of their subordinate position in the household, the long periods of time spent in the home and the extra demands on them for housework, child-rearing and so on in the home (Gabe & Williams 1986; 1987; 1993). It is suggested that women living in high density housing may have little control over the amount of social interaction with other household members, they may have difficulty in gaining control over personal space or achieving a desired level of privacy. Gabe and Williams' findings, however, also highlighted the possibility that low living densities may also have detrimental effects on mental health. They proposed many explanations for this finding: low density may mean less social interaction with other members of the household; the perception of space may itself engender a sense of loneliness; the amount of housework to be done in spacious accommodation may be seen as a burden, especially since women shoulder most of the responsibility for housework; and space may create problems for child supervision. They concluded, therefore, that there may be an optimal level of density in the home for psychological health.

1.2.4 Residential location

Residential location can determine exposure to spatially variable environmental hazards. Radon gas as a pollutant of indoor air and possible cause of some cancer has, however, received much attention in recent years (Lowry 1991), gaining a mention in the current health Green paper. The distribution of radon is primarily determined by geology – it is present in almost all rocks and soil, but especially granite – and as such indoor concentrations of the gas vary geographically. In parts of south west England, the mean concentration is fifteen times the national average (Lowry 1991). For most people in Britain, radon is the single largest source of exposure to radiation. Indeed, exposure to indoor radon has been estimated to account for as much as 6% or more of the annual incidence of lung cancer (Clarke & Southwood 1989; O'Riordan 1990). But while studies have shown that exposure to radon may cause lung cancer in uranium miners, there appears to be no direct evidence linking areas of high domestic exposure with an increased risk of lung cancer (Samet & Nero 1989), though it may be linked to some cases of myeloid leukaemia (Henshaw *et al.* 1990).

Continuous noise, particularly from neighbours, traffic or nearby street repairs can be irritating and distressing (Ineichen 1993; Lowry 1991). Perceived risk (which may or may not relate to actual risk) of crime varies geographically and has been linked to feelings of anxiety (Smith 1989a). A number of British (Perry *et al.* 1981; Perry & Pearl 1988) and American (London *et al.* 1991; Savitz *et al.* 1988; Wertheimer & Leeper 1979) studies have raised the possibility of a link between residential proximity to major electrical supply cables and depressive illness, even suicide, heart disease and childhood cancer (see Best 1990 for a review of the literature). Interference with cardiac pacemakers and metallic surgical devices has also been reported (Aw 1988). Another study (Fulton *et al.* 1980), however, showed no increased risk of childhood leukaemia. Moreover, as yet, no plausible causal mechanisms have been identified (Gurney *et al.* 1994).

In a study of council tenants in Gateshead, (Byrne *et al.* 1986) found that people living in difficult-to-let housing areas reported more illness, especially respiratory disease and psychological stress, and suggested that the differences between areas could be explained more by location than by dwelling type. Blackman *et al.* (1989) also found significant differences in health status, accident rates and psychological distress in Belfast between the residents of an estate with very poor conditions and one where the housing was regarded as significantly better. Even those with a good dwelling on the poor estate were at higher risk of ill-health than those with a bad home on the better estate. Recent work in Newcastle suggests further that the neighbourhood in which tenants live has a significant independent effect on stress levels (Blackman *et al.* 1993). Thus as Taylor (1979) has pointed out, to term these estates 'difficult-to-let', ignores the experience of the tenants who live there, for who they might more accurately be described as 'difficult-to-live-in'. Nevertheless, these findings should be of interest to council housing managers who have increasingly over the past two decades found their housing stock to be concentrated in such areas, as better dwellings in more popular areas were purchased under the Right to Buy legislation first introduced in 1980.

Residential location has also been implicated in the opportunity to live 'healthy lifestyles'. The last health strategy urged people to eat less fatty food and exercise more (Secretary of State for Health 1992). Macintyre *et al.* (1993), on comparing two socially-contrasting residential areas in Glasgow, showed that access to sports facilities were more limited in the poorer one (where housing conditions were also worse). Similarly, the type of foods regularly recommended in government health

documents were found to be more expensive and less available in this area (Sooman *et al.* 1993). What this means is that where you live might be an important determinant of your ability to promote your own health – a point recognised in the new health Green Paper.

The location of the home may also be an important determinant of the availability of, and access to, informal support and care networks, provided largely by family and friends. It seems likely that feelings of isolation and loneliness can contribute to symptoms of psychiatric disorder, particularly depression. Martin *et al.* (1957) found, for example, a surprisingly high incidence of psychological disorder amongst the residents, particularly women, of a new suburban housing estate in Hertfordshire. It was argued that women in particular missed the close-knit communities of the higher density inner-London areas they had moved from. It is unclear however how much of this increased incidence of mental illness could be attributed to the actual process of moving home and how much of the reported gradual improvement in mental health was linked to acceptance of the new situation, having made new friends or having recovered from the stress of the moving process. Other studies (Taylor & Chave 1964; Hare & Shaw 1965) did not find any difference in the prevalence of mental illness between the inhabitants of suburban housing estates and inner city boroughs.
Social support is also often vital for those vulnerable people who wish to live independently in their own homes but where this can be dangerous to health if help with everyday chores is not available. It has also been suggested, moreover, that for households exposed to moderate (though not high) levels of housing stressors – or poor conditions – support from relatives is associated with reduced stress (Smith *et al.* 1993). Thus social support, if available, can sometimes reduce the harmful effects on mental health associated with poor housing.

Residential location similarly has important implications for access to formal health care. Tudor Hart (1971) coined the now-famous phrase 'inverse care law' to describe the inequitable distribution of health services, whereby deprived areas – largely areas of poor housing – where health need is greatest are often poorly serviced by health services. More recent studies have continued to report similar findings (Macintyre *et al.* 1993 and see also Whitehead (1992) for a review of the literature on this subject). Residential location is particularly important for gaining access to many parts of the primary health care services and Macintyre (1989) suggests that inequalities in access to these services could influence the (social) distribution of disease or death by the differential take-up of the preventive procedures such as immunisation offered.

Although there is actually little evidence to suggest that inequalities in access to health care *cause* inequalities in health, what this might mean is that those people who are already at increased risk of ill-health due to their poor housing conditions and housing environments among other things, are also less likely to be given the opportunity to take preventive action, further reinforcing existing inequalities in health. For those who already experience ill-health, whether caused by their poor living conditions or not, access or lack of access to health care and treatment may affect their potential to cope with their illness, their experience of it and as a result, their quality of life.

1.2.5 Moving home

Residential mobility has been identified as one possible stressful life event that can lead to, or exacerbate, mental illness and related physical (psychosomatic) disease (Holmes & Rahe 1967; Metzner *et al.* 1982; Smith 1989a). It can be particularly stressful for women (Brett 1980; Dimond *et al.* 1987), older people (Rowland 1977; Kasl 1984) and when the move represents forced re-location (Stokols & Shumaker 1982). The upset associated with moving home may not, however, be enduring. Hooper and Ineichen (1979) and Dimond *et al.* (1987) found evidence of an adjustment effect, for instance. Moreover, the inconvenience of moving may be offset if the move is viewed positively and leads to benefits such as employment or improved housing and/or location (Stokols & Shumaker 1982).

Other studies have also shown that, while upsetting for some, moving home can, for others, be represented as a means of *reducing* stress and improving health and well-being (Clark & Cadwallader 1973; Stokols & Shumaker 1982; Stokols *et al.* 1983; Elton & Packer 1987; Deane 1990; Kearns *et al.* 1992). Residential mobility may be a mechanism employed deliberately in the attempt to secure more suitable housing and improve access to care and support in the face of chronic ill-health, especially among the elderly (Litwak & Longino 1987; Meyer & Cromley 1989). It seems reasonable to expect that when the home has detrimental effects on occupants' experience of health, either through causing or increasing susceptibility to disease, exacerbating illness or disability, or impeding access to care and support, then residential change may be able to cure sickness, alleviate suffering, enhance access to care and/or improve ability to cope with ill-health. In some circumstances, therefore, staying put can be the least healthy option (Ineichen 1993; Leather & Mackintosh 1993a; Kearns *et al.* 1992), and moving home may be seen as a means of promoting health.

This is not to argue that residential mobility represents the only, or even the most effective, solution to the problem of poor housing and ill-health. Clearly the ideal solution would be to eradicate the problem of unhealthy housing altogether. In practical terms, however, this is unlikely to happen in the near future (if at all). My argument here, therefore, is that moving sick and disabled people from accommodation that is unsuitable for their health needs to other parts of the housing stock that *is* suitable, is, in the meantime, one means of securing health gains.

1.3 Ill-health and housing opportunities

The above discussion suggests that while poor housing is directly and indirectly harmful to health, good housing can promote health and well-being for sick and disabled people. Housing may therefore represent an important instrument of health and social care (Conway 1995; Laws & Dear 1988) and residential mobility may represent one strategy for securing health and quality of life gains. Conversely, then, if there are barriers to such mobility, these could have important public health consequences.

In direct contrast to the long history of academic interest in the effect of poor housing on health, the effect of health status on housing opportunities has remained largely unexplored. Smith (1990a) first introduced the idea of a 'health selective' effect in the housing system and provides an excellent discussion of the subject in the British context. Since then research in other industrialised nations has begun to show how people with health needs can be marginalised in the housing system, gaining limited access to homes suited to their needs (Elliot *et al.* 1990; Kearns & Smith 1993; Kearns *et al.* 1994; Lamb & Lamb 1990). Poor health, it seems, can affect housing attainment so that sick people – the very people who spend most time in the home and who are therefore most susceptible to its harmful effects – have the double burden of living with illness or disability in unhealthy homes. And what this suggests is that the opportunities for this group to employ residential mobility as a means of enhancing their experience of health and their quality of life is limited.

In Britain today, the housing system consists of a large private sector – including the owner occupied and private rental sectors – and a smaller social rented sector – including the local authority and housing association sectors. In the private housing system housing – as a commodity – is distributed primarily according to ability to pay.

In the social sector – as a welfare service – it is allocated, by contrast, according to various definitions of 'need'. Smith (1990a) argues that, just as race and gender have been shown to affect both access to housing finance and social housing allocations opportunities (Henderson & Karn 1984; Jeffers & Hoggart 1996; Watson 1986, 1988), whether housing resources are allocated according to ability to pay or need, the process is health selective. Health status may therefore be an important determinant of people's ability to secure a home – and a decent home – in both the private and social sectors.

This is the empirical starting point for the present thesis. From this starting point it is evident that the relationship between housing and health is even more complex than the discussion in Section 1.2 suggests. It may, for instance, increasingly include not just the effect of poor housing on health, but the effect of poor health on housing attainment. Thus inequalities in health and in housing are inextricably linked and are implicated in the reproduction of one another, with the two fundamental elements of the relationship between housing and health simply representing, as McGuckin and Smith (1991) argue, 'two sides of a single coin'. Thus although these different links have hitherto represented rather distinct areas of research, policy responses to the issue of housing and health should attempt to address both.

However, just as academic research has tended to concentrate on one, rather than the other, aspect of this complex relationship, the next section goes on to show that the same has been true in the (housing) policy sphere. While the harmful effect of poor housing on health has long been recognised – and addressed – in housing policy, the idea of a health care role for housing has been relatively neglected and the issue of access to suitable housing for people with health needs in order to take advantage of this role is an issue that remains widely unaddressed today.

1.4 Housing policy and practice and health

There is a long tradition in Britain of employing housing interventions to promote public health. Indeed it was recognition of the effect on the poor urban masses of their unhealthy living conditions in the middle of the last century, that led to the first state interventions in the housing system, and, it has been argued, 'policy and practice with regard to housing and health can be seen as having gone hand in hand in this country' (Byrne *et al.* 1986, p.1) for many years since.

Policy responses have, however, varied (Ormandy 1987). To some extent this reflects the growing understanding of the various links between housing and health (as described in Sections 1.2 and 1.3), but McGuckin and Smith (1991) argue that the way in which these fundamental relationships have been tackled through time has also closely reflected the dominant roles that society (or government) has seen for housing policy.

Clapham *et al.* (1990) suggest, for instance, that viewed historically housing has, at different times and often simultaneously, been seen as a tool of environmental management, as a social service and as a marketable, privately-owned commodity. Each of these roles suggest different approaches to, and commitment to breaking down, the relationship between housing and health (McGuckin & Smith 1991). Since the various roles for housing must usually be negotiated alongside one another, the approaches associated with each, moreover, vary depending on the influence and dominance of these other roles at any one time. A brief history of health-related housing policy and practice shows how, ultimately, the response of the housing system to the issue of housing and health is largely determined therefore by political ideology.

1.4.1 Housing and the sanitary theme

The first health-related interventions in the housing system – which in fact represented the first state intervention in the housing system generally – came in the mid-nineteenth century through a series of sanitary and public health measures (Clapham *et al.* 1990; Gauldie 1974; Byrne *et al.* 1986; Smith 1989a). Set within the context of a dominant societal view of housing as private property and a commodity in which property rights were sacrosanct and government interference in the housing system was not acceptable, these did not represent housing policy *per se* (Gauldie 1974; Ormandy 1987). They were, however, based on the idea of a role for housing as a tool of environmental management and a belief in the need for some collective (state) responsibility for, and public regulation of, housing environments (Burridge & Ormandy 1993; Clapham *et al.* 1990).

Improved living conditions, it was believed, would lead to the prevention of disease among the poorer classes currently living in over-crowded, substandard private-rental accommodation in the slum areas of the rapidly-growing towns and cities (and

prevention of the spread of disease to the richer classes in their more spacious suburban surroundings). Thus a series of Public Health Acts (in 1848, 1872 and 1875), Nuisance Removal Acts (in 1846, 1848, 1849 and 1855) and the Sanitary Act 1866 were designed to improve dwelling sanitation through the provision of basic amenities and the maintenance of buildings, and to set minimum standards for construction and amenity provision (Gauldie 1974; Clapham *et al.* 1990). Local authorities were exhorted to clean streets and to provide an adequate water supply, for instance, while minimum cubic contents of rooms were specified and space in front of and behind buildings were now necessary (Nuttgens 1991).

By the second half of the nineteenth century, the importance of the sanitary theme and a public health-informed regulatory role for the state, had also been established in housing legislation. The Artisans' and Labourers' Dwellings Act 1868 and the Artisans' and Labourers' Dwelling Improvement Act 1875 gave local officers of health and, after 1872, the professionally-qualified Medical Officers of Health the power to inspect and report on houses that were 'in a condition or state dangerous to health as to be unfit for human habitation' (Malpass & Murie 1994). They had the power to force the owners (private landlords) to repair them or have the authority demolish them (Clapham *et al.* 1990; Malpass & Murie 1994), and, for the first time after 1875, to provide replacement housing (Lowe 1991). These powers were consolidated in the 1890 Housing of the Working Classes Act.

Although these Acts represented a recognition of the failure of the private housing market to provide adequate housing for the poor, none had much impact as many medical officers were reluctant to use their powers. Slum clearance without adequate replacement, as they were only too aware, would serve only to make matters worse by increasing levels of overcrowding in nearby areas (Malpass & Murie 1994). Despite the powers afforded to them, local authorities were not keen to take over the role of providing dwellings for the poor (not least because many local authority officials were already themselves private landlords) and indeed, during this time, more dwellings were demolished than were built. This was a role that would have to wait for a different political context and another century. The private housing market continued to dominate, largely unfettered.

The use of building and planning regulations (which impose space standards and control building materials, lay out and location of dwellings), statutory controls on overcrowding and sanitation, official standards of fitness for human habitation and

local authority dwelling inspection (now by Environmental Health Officers), however, continue to play a role in the promotion of a healthy housing stock in modern day Britain (Burridge & Ormandy 1993; Smith 1989a).

1.4.2 State housing provision, slum clearance and environmental renewal

Although it has been argued that by the early decades of the present century, health concerns were no longer the driving force behind housing policy and have remained side-lined ever since (Smith 1989a), two important elements of housing policy this century have – if implicitly – represented a further, different, approach to the problem of poor housing and ill-health.

This approach was again based on an environmental management role for housing in the prevention of disease. But in a step forward from the largely regulatory role of local authorities in the previous century, this strategy has involved the use of public resources in the direct removal of the least healthy living environments and, for the first time, providing or ensuring better ones. This has involved large-scale slum clearance together with state-subsidised (replacement) housing provision, and publicly-funded environmental renewal.

Although earlier housing acts had allowed for local authorities to provide housing to replace that which they cleared, it was not until the 1919 Housing and Town Planning etc. Act (the Addison Act) that they were placed under legal obligation and provided with Exchequer subsidy, to do so (Lowe 1991; Malpass & Murie 1994; Merrett 1979).

For some commentators, the provision of subsidised rental housing by the state through local authorities was a natural and logical progression from their earlier involvement in disease prevention through the regulation of private provision. It was the direct result of a recognition by the state of the failure of the private sector to provide healthy housing for a substantial proportion of the working population (see Burridge & Ormandy 1993 and Wohl 1977 for example). The reasons behind this new provider role are undoubtedly more complex than this (Kemp 1991) and almost certainly include a concern to meet the housing shortage that developed during the War and to quell any threat of social unrest that a failure to do so might evoke (Swenarton

1981; Kemp 1991). Nevertheless, it seems likely that public health issues played their part.

Byrne *et al.* (1986) argue, for example, that such working class demands for the right to decent shelter were, at least in part, based on a newly-formed popular understanding of the 'social epidemiology of housing and health'. Moreover, those in favour specifically of a direct state involvement in housing provision and who had been pressing for the adoption of part III of the 1890 Housing of the Working Classes Act which allowed for this were usually an alliance of labour representatives and local medical men. The ministerial affiliation of housing and health issues (from 1919 government responsibility for housing was vested in the newly-established Ministry of Health) also made it seem unlikely that the links between the two would be forgotten completely at the government level. Thus the four Housing Acts that established council housing provision were introduced – and named after – four Ministers of Health (the Addison, Chamberlain, Wheatley and Greenwood Acts of 1919, 1923, 1924 and 1930 respectively). Certainly it has been argued that one of these in particular – the Housing (Financial Provisions) Act 1924 – introduced by the Labour Minister, John Wheatley, was influenced by his own experience of the strong relationship between poor housing and ill-health in his home town of Glasgow, where he had previously campaigned on the issue (McFarlane 1989).

Slum clearance programmes were undoubtedly given extra impetus as those displaced would now – unlike previously – be rehoused by the authority in more decent housing (and indeed during the 1930s and 1950s council housing was largely concerned only with slum clearance and replacement provision). The 1930s slum clearance efforts were viewed implicitly as the housing route to better health (Smith 1989a), and were based on much the same kind of reasoning as that which underlay the earlier sanitary and public health legislation (Burnett 1986; Burridge & Ormandy 1993; Clapham *et al.* 1990). Thus although never adequately defined by statute, 'slums' , as defined in the new statutory definition of fitness, were designated according to similar criteria to that of the earlier era of sanitary reform, and again, largely at the discretion of the medical officer of health (Moore 1987; Clapham *et al.* 1990). Indeed, an expanding public provision was regarded as a way of systematically replacing the privately-rented, inadequate, overcrowded, over-priced and unhealthy homes of the inner cities with an affordable (subsidised) alternative, built to minimum standards, that would be centrally monitored, managed and maintained (Burridge & Ormandy 1993; Ineichen 1993).

Slum clearance became the dominant element of public housing policy once again in the 1950 and 60s (Stewart 1987), but by this time the health dimension to housing policy had all but disappeared, reflected not least in the official divorce of health and housing policy as the responsibility for housing was transferred from the Ministry of Health to the newly-created Ministry of Housing and Local Government (Byrne *et al.* 1986; Smith 1989a). Thus although slum clearance was again based on the standard of fitness for human habitation and the sanitary theme was continued further in a series of Housing Acts from the late 1950s onwards that required local authorities to give preference in their housing queues to people living in overcrowded, insanitary and other unsatisfactory conditions, Byrne *et al.* (1986, p.24) refer to this era in housing policy as 'slum clearance without consideration of health'. The replacement housing built at this time has been described as 'mass housing' (Dunleavy 1981) since it mostly consisted of high rise blocks of flats that had seemed to offer the promise of quickly-produced, high-density, low-cost accommodation capable of meeting the large demands for new housing (Lowry 1991). It is hardly surprising that the biggest contribution to the contemporary stock of 'unhealthy' housing is now made by the first public housing to be built with little consideration of health but considerable profit-making potential for large construction companies trying out new, untested building techniques (Dunleavy 1981; Byrne *et al.* 1986; Lowry 1991).

Comprehensive slum clearance largely came to an end during the early 1970s, as the *in situ* rehabilitation of the private housing stock replaced it as the main mechanism of environmental management through housing interventions (Clapham *et al.* 1990; Merrett 1979). Discretionary improvement grants had been available since 1949 and mandatory since 1959 (Burridge & Ormandy 1993) but together the 1969 and 1974 Housing Acts introduced the idea of private housing *improvement* as an alternative to slum clearance. Fitness standards, once used to justify clearance, were now (and continue to be today) invoked by Environmental Health Officers to identify those dwellings to be afforded improvement grants, and thus grant aid replaced compulsory purchase and local authority provision as the main mechanism for removing unhealthy living environments (Burridge & Ormandy 1993). Initially, as with slum clearance, much of this improvement activity was area-based (Moore 1987) – the Acts introduced General Improvement Areas and Housing Action Areas – but as local government expenditure became increasingly constrained, area action declined and was increasingly replaced by a targeting of resources on individual households.

Politicians often sought to justify this shift in policy emphasis from slum clearance to home improvement in social and health terms. But academic research had already begun to document the detrimental effect that relocation following slum clearance had on family ties, social networks and mental health (as described in Section 1.2.4). However the shift actually represented the decreasing commitment of governments – Conservative and Labour alike – to the large-scale provision of public sector housing that slum clearance required (Clapham *et al.* 1990; Merrett 1979).

1.4.3 Housing as health care: medical priority rehousing

It is ironic that, at the same time as a shift in emphasis from publicly-funded slum clearance and redevelopment to *in situ* rehabilitation of the private housing stock all but displaced health issues from the housing policy arena, the most comprehensive British housing for health strategy emerged (Smith 1989a). This strategy is, moreover, one based on state-subsidised housing provision. It represents the third and final approach to the issue of housing and health to be discussed here and is based on a role for housing as a *social service* – the last of the three roles mentioned above. It is one that sees housing as an instrument of health and social care.

The 1948 National Assistance Act first introduced the idea of a 'caring' role for housing (Smith & Mallinson 1997). It charged local authorities with the responsibility of providing homes for people who 'by reasons of age, infirmity or any other circumstances are in need of care or attention'. For the post-war Labour government, local authority housing, as an integral element of the newly-founded welfare state, was to be viewed as another social service concerned with the care and support of the population (Spicker 1989) and the role of housing as an instrument of health and social care was established. Since then the 1970 Chronically Sick & Disabled Persons Act has required local authorities to take into account the housing needs of this group and the recent Conservative 1996 Housing Act also urged them to give priority consideration to 'households consisting of or including someone with a particular need for settled accommodation on medical or welfare grounds'. But the task of developing this health and social care role has fallen largely to social housing providers themselves.

As early as the 1920s and 30s some progressive local authorities had begun to recognise that sick people might benefit from access to healthy homes and were

already allocating some of their newly-built dwellings specifically on the grounds of ill-health. In 1929 Glasgow Corporation began operating a scheme to rehouse those overcrowded families containing an active case of respiratory tuberculosis as recognised by the medical officer of health. Ten per cent of the city's new 'intermediate' houses were set aside for such families, who were given priority on the housing waiting list. By 1948, almost 2,000 families had been rehoused in this way (McFarlane 1989).

However it was not until the early 1970s that the idea and practice of awarding priority on the grounds of ill-health in the public housing queues increasingly gained currency. By the end of the decade virtually all local authorities had in place the mechanism to recognise the importance of, and incorporate into allocations, a wide range of medical needs (Smith 1990a; Smith & Mallinson 1997). It is, moreover, this system – widely known as medical priority rehousing (MPR) – that has come to represent the most important intervention of the housing system in issues of housing and health.

In a link with earlier 'healthy' housing practice, medical priority rehousing has been employed as a means of preventing disease and curing illness, thereby fulfilling an environmental management role. Moreover, it has largely been public health professionals – the modern day Medical Officers of Health – who have been involved in deciding who should benefit from the assignation of medical priority (Easterlow & Smith 1997). However, the links between housing provision and health and social care servicing have also been recognised and addressed through medical rehousing. Medical priority has been available, for instance, on the grounds that rehousing can not only lead to relief of symptoms, prevention of disease and improvements in health, but can improve access to care and support and enhance quality of life.

But the system of medical priority for rehousing developed at the same time as governmental commitment to the idea of direct state provision of housing, on which it is based, was declining. In particular, since 1980, three successive Conservative governments have sought to promote the private housing system – and a role for housing as a private, wealth-creating commodity – at the expense of the state-subsidised sector. Conservative housing policy revolved around dismantling the local authority sector – resulting in a decline in its size for the first time in its history – rather than developing further its involvement in issues of housing and health. This thesis is concerned with the implication of this for the opportunity of people with health and mobility needs to secure health gains through housing interventions.

To sum up this section, British housing policy has, for more than 100 years, recognised, if only implicitly, the importance of good housing in promoting public health. A number of approaches to the issue of housing and health have been implemented, including state regulation of the private housing system and of housing and construction standards, the strategies of slum clearance and state provision, and environmental renewal. All, however, have been based on a recognition of the failure of the private housing system to provide healthy homes for large sections of the population and on the need, therefore, for a collective responsibility towards the problem of unhealthy housing. For much of this time attention has focused on a role for housing in preventing disease – as a tool of environmental management. Links between health status and housing opportunities and between housing provision and health servicing have been acknowledged more recently, particularly during the past twenty-five years. A role for housing as an instrument of health care, linked to its wider role as a social service, is one, however, that has not been based on national policy directives, but on local social sector housing initiatives, in particular local authority and housing association schemes to allocate housing on health grounds. Indeed, this is a housing for health strategy that has emerged, developed and operated (and perhaps, as a result, been increasingly compromised) as health issues have largely disappeared from housing policy. Housing policy has been concerned instead, particularly during the 1980s and 1990s, with promoting wealth (through owner occupation) rather than health, and a role for housing as a commodity in a context of reduced state involvement in housing provision and in ensuring healthy living conditions.

1.5 Health policy and housing

Despite the almost disappearance of health concerns from housing policy in recent decades, government health strategies have, on the other hand, begun to recognise once again, the important role of good housing in promoting the nation's health, and, at the same time, opened the door to a reconsideration of the health aims of all public policy, including that of housing.

Health and health care policy over the past decade has largely been concerned with two issues. The first of these has involved the reorganisation of the provision and delivery of health care by the National Health Service (NHS). The Conservative NHS and Community Care Act 1990, for instance, introduced the 'internal market' into the

NHS, and with it the separation of the planning and delivery of health care (Appleby 1994; Glennerster & Matsaganis 1994; Ham 1994; Mohan 1995). The recent Labour document *The New NHS* (Secretary of State for Health 1997), although maintaining the distinction of the planning and provision functions, pledges to abolish the internal market and replace it with a system of 'integrated care'. Both reorganisations involve the restructuring of health care in an attempt to maximise efficiency while maintaining the principle of universal, comprehensive coverage, free at the point of use.

A second strand of recent health policy, and one of particular interest to this discussion, has been concerned with reducing the role of the NHS in promoting the nation's health and in providing its health care. It has been based on a move away from the role of the statutory health and caring services towards the idea of service partnerships and sectoral alliance and towards care in and by the community. This shift is important because, in both cases, it affords, indeed requires, a greater role for housing in public health strategies (Smith & Mallinson 1997).

Caring for People (Secretary of State for Health 1989), a Conservative White Paper of 1989, was concerned with the issue of community care. It continues the long commitment of British governments (including the current Labour government) to both the closure of long-stay institutions for the mentally ill and those with learning difficulties, and to enable older people and those with physical disabilities to remain in their own homes (Clapham *et al.* 1990; Mohan 1995). These objectives will be achieved through the development of community-based support services.

Ideas of community care have long been predicated on the assumption that the caring role is largely carried out by (mostly female) family and friends. Throughout the 1980s and 1990s, Conservative administrations were keen to emphasise that care in the community must increasingly mean care *by* the community. Not only did *Caring for People* acknowledge that most care is provided on an informal, unpaid basis by relatives but implied that this is their duty (Mohan 1995). Whatever the ethical dimensions of these presuppositions, to the extent that community care relies on informal care in the home, it also depends on a housing strategy that is concerned with the availability of good quality, suitable, enabling dwellings (Clapham 1991; Means & Smith 1994), and with facilitating the close residential proximity of carers and those they care for. Indeed *Caring for People* itself recognises that 'housing is a vital component of community care and is often the key to independent living' (p. 25), and although no specific responsibility was accorded to the statutory housing agencies,

social service authorities – the lead organisation in community care provision – were expected to work closely with local housing authorities, housing associations and other providers of housing.

Two further government documents on health this decade – the Conservative *Health of the Nation* White Paper (Secretary of State for Health 1992) and the Labour *Our Healthier Nation* Green Paper (Secretary of State for Health 1998) – similarly base their strategies for promoting England's health and well-being on a reduced role for the NHS. They are concerned with securing a continued improvement in the general health of the population by preventing disease and premature death, and with promoting the health and quality of life of those who suffer from chronic ill-health and disability.

Both recognise that the causes of poor health and well-being include social and environmental factors as well as individual behaviour, and that the activities of a range of organisations, including government, impinge on the public's health. Thus the new role of the NHS lies in promoting and developing 'healthy alliances' with these agencies in the bid to ensure healthy living and working environments as well as healthy lifestyles. Similarly, England now has a Minister for Public Health whose specific responsibility is to co-ordinate policy across government departments and all government policy is appraised for its effect on public health. Although the *Health of the Nation* placed much emphasis on the role of the individual in promoting and determining their own health, it did recognise that 'good housing is important to good health' (p. 28). The new Green Paper acknowledges to a greater extent the social and material determinants of health and well-being, and recognises, in particular, that 'housing has an important impact on health' (p. 18). Thus Government recognises that one of its own public health roles is to ensure decent housing for all, and that local authorities with their responsibilities for housing, 'have the capacity to make a very real impact on the health of the communities they serve' (p. 44).

What all this means is that not only is the importance of good housing in promoting good health recognised once again in the national policy sphere, but that health gains and the provision of health care might be regarded as a legitimate objective for both housing policy and the housing system.

1.6 About the thesis

My argument throughout this introduction has been that if poor housing can harm occupants' health, and the evidence suggests it can, then good housing, and moving to more suitable housing, might have important therapeutic and palliative effects for sick and disabled people. In other words, good housing might be viewed as an instrument of health care.

In the context of health policy that once again opens the door to a central role for the housing system in promoting the nation's health, this thesis will explore the opportunities available to people with health and mobility needs in England to gain access to the type of housing that can meet their needs and promote their health.

For much of the post-war period, and particularly for the past 25 years, medical need has afforded sick and disabled people in Britain, privileged access to the social housing system through the system of medical priority rehousing. Housing managers have recognised medical need as a valid indicator of housing need, and priority – medical priority – in the housing queues has been awarded to people with health and mobility problems accordingly. Medical priority rehousing is a housing service that explicitly aims to provide housing opportunities for people who want to move because their health needs cannot be met in the current home.

Over the past eighteen years, however, the social housing system has been radically restructured. The state-subsidised housing sector has declined in both size and quality, as the private sector has grown at its expense. It is in this context that the thesis will therefore concentrate on the health (care) opportunities provided by a shrinking and privatised social housing system for sick and disabled people in England in the 1990s, before briefly turning its attention to the enlarged private housing system.

The system of medical priority rehousing developed in the early 1970s when the social housing sector was still growing in absolute terms. However, since then the context within which this part of the housing system has fulfilled a health care role in this way has changed. Chapter Two documents the restructuring of the social housing sector that has taken place since 1979. Drawing on a database of housing and health indicators (see Appendix I) it suggests that the effects of national housing policy over the past two decades may have been to compromise the ability of the medical priority system to contribute to current health policy aims.

It is in this context that Chapter Three introduces in more detail the idea of awarding priority in the social housing queues on the grounds of ill-health. It argues that the concept of housing allocations according to health need may be one that is difficult to operationalise, but that this is especially true now in the 1990s following the decline of the social housing sector. The chapter also suggests that as a result, people with health needs may face barriers to securing suitable homes in the sector in the form both of housing shortages and rationing strategies employed by housing managers in the bid to match demand for medical priority with available resources.

Chapters Four to Six explore these charges. These chapters are based on the secondary analysis of a series of quantitative surveys and case study visits conducted as part of the first (and only) national study of housing provision for people with health problems and mobility difficulties in England (Smith *et al.* 1992). This data set provides the most comprehensive information on the system of medical priority for rehousing to date, allowing for an in-depth exploration of both the operation and management of medical priority rehousing schemes, and the opportunities they provide to people with health and mobility problems throughout England. A more detailed description of the study and the data available is provided in Appendix I.

In apportioning medical priority, housing managers have traditionally relied on medical judgements from health professionals. Chapter Four explores the role and relevance of health professionals in housing management in this way. It considers the effectiveness and appropriateness of such a partnership in managing medical priority schemes and in allocating housing on health grounds. It also provides a commentary on the possibilities for inter-agency partnerships that are currently in vogue in health policy.

Chapters Five and Six look at how housing officials themselves manage demand for medical priority rehousing. They consider the range of ways that housing managers and housing officers attempt to ration access to the medical priority system and the medical rehousing process. The chapters are concerned with what the implementation of such rationing strategies means for the opportunities of sick and disabled people to secure the favourable housing and health outcomes potentially associated with medical priority rehousing. They consider the problems faced by people with health needs in gaining access to the medical priority system (Chapter Five) and in securing a suitable home through it (Chapter Six). The chapters therefore consider the extent to which

medical priority rehousing represents an effective healthy housing service for sick and disabled people in England in the 1990s.

After concluding that medical priority for rehousing represents a valuable housing for health service but that opportunities to meet the housing needs of people with health and mobility problems are increasingly limited, Chapter Seven turns the attention of the thesis to the private housing system. It considers the interaction of health status and housing market opportunities, exploring the accessibility and suitability of owner occupation and private renting for people with health needs. The chapter explores, therefore, the extent to which private sector housing interventions might be employed as a means of promoting the health and quality of life of those sick and disabled people who are excluded from, or do not wish to enter, the social housing system. Here I draw on previously unpublished pilot interviews conducted in Edinburgh (see Appendix I) and on the wider housing literature. In this way, the thesis provides an overview of the capacity of the whole housing system to contribute to current public health and community care aims.

Chapter Eight represents the conclusion of the thesis. It sums up the main findings of Chapters Two to Seven. In light of these it makes a number of recommendations on ways to improve the effectiveness of the housing system – including the social and private sectors – in promoting the health and quality of life of people with health and mobility needs through housing interventions.

2

THE PRIVATISATION OF SOCIAL HOUSING PROVISION: HEALTHY HOUSING POLICY?

2.1 Introduction

Chapter one argued that the availability and affordability of 'healthy homes' is important to the success of current national health strategies. It also showed how national housing (or housing-related) policy and local housing practice have, for more than 100 years, been concerned, albeit for much of that time only implicitly, with the health of the population. Such policy has been particularly concerned with those households who are unable to secure healthy housing in the private housing market. A number of approaches to breaking the complex link between unfit or unsuitable housing and ill-health have been implemented. The most important of these, as we saw, have rested on the allocation of state-subsidised housing, including a role for housing both in preventing and curing disease, and as an instrument of health care.

The term 'social housing' has been used, in the western European context, to describe a range of state interventions in the housing system, but is generally taken to refer to 'housing provided on a non-profit basis and independently of ability to pay.... [and thereby providing].... an alternative to the unfettered market' (Doling 1994, p.246). In some countries, like Finland and Iceland, certain forms of owner occupation are included in this category, though on the whole it has been restricted to rental housing. Social or state-subsidised rented housing can also take a number of different forms, and indeed such housing has traditionally been provided in a very different way in Britain to most other European countries. In the rest of western Europe, social rented housing has largely been developed and managed by non-profit organisations, independent of local government but funded by central government (perhaps resembling British housing associations) (Cole & Goodchild 1995; Emms 1990;

Kleinman 1991, 1993). In Britain, by contrast, for much of the history of social housing, the emphasis has been on the provision, ownership and management of housing directly by local government – council housing.

1919 marked the first turning point in the history of state-subsidised housing provision in Britain, when Exchequer subsidies for its provision by local authorities were first introduced. Prior to this date, state intervention in the housing system had occurred mainly to regulate private provision. Throughout the next sixty years, although no real consensus existed between the two main political parties, nor between successive governments, on the role and importance of council housing (Forrest & Murie 1988; Malpass & Murie 1994), the stock of local authority dwellings grew (Malpass 1993) and council housing was seen as the normal mode of provision of rented housing (Kemp 1990), with housing associations providing a more limited, complementary, specialist role (Best 1991).

The first election of a Conservative government under the leadership of Margaret Thatcher in 1979, however, marked a significant change in approach towards social housing (Forrest & Murie 1988). A suite of housing policies, spanning three terms of office and eighteen years, were to change the face of state-subsidised rented housing provision in this country. The context within which social housing has, for more than fifty years, been employed as a health intervention has therefore been transformed, and it is important to this thesis to show how. That is the aim of this chapter.

Chapters Four to Six employ national data on the system of medical priority rehousing (MPR) in England in order to explore the capacity of the social housing sector to continue assisting people with health problems to move to housing suited to their needs within the sector in the 1990s. The data were collected at the beginning of this decade, by which time many of the Conservative housing policies directed at the social housing system were in place and had begun to take effect. Recent health strategies (Secretary of State for Health 1992, 1998) suggest that the implications for the nation's health of all government policies should now be assessed. What this chapter aims to do, therefore, is explore the consequences of Conservative housing policy, which has been concerned largely with extending the right to wealth (through home ownership) rather than health, for a long-established example of local housing practice designed explicitly to promote health and well-being. As such it will also provide the general housing policy context for the detailed findings on the operation of medical priority rehousing in the next few chapters.

2.2 Social housing provision and the restructuring of welfare

Over the past twenty years the welfare systems of most developed nations, including those of western Europe, have been subject to wide-ranging policies of restructuring and retrenchment. A sustained period of rapid economic growth following the Second World War was accompanied by an expansion in welfare expenditure. As this growth came to an end in the early to mid 1970s, so it was too that the desirability of the continued growth of state responsibility for public welfare came to be questioned (Clarke & Langan 1993; Doling 1994; Flynn 1988). Rising unemployment and demographic change (in particular, an ageing population), coupled with a slowing rate of growth or a decline in GDP and balance of payments difficulties meant that pressure was increasing on welfare systems at the very time governments argued they were less able to finance them. Indeed for some, the growth of public sector spending – welfare spending in particular – came to be identified as the 'evil' that stifled the growth of the economy (OECD 1985). Governments throughout western Europe began to implement strategies of welfare retrenchment. Despite the common experience of these economic problems, responses have, however, varied enormously in terms of their pace, direction and scale, largely reflecting differences in government ideology and welfare traditions (Clarke & Langan 1993; Doling 1994; Flynn 1988; Smith & Mallinson 1997). What is interesting, however, is that state-subsidised housing has lain at the heart of these strategies in most, if not all, cases (Ball *et al.* 1988; Doling 1994).

It has become clear in recent years that the retrenchment of most welfare systems has not been as radical as initially expected. Indeed, the evidence seems to point to the fact that far from contracting, welfare expenditure has actually risen in most European nations (Doling 1994). In fact, welfare restructuring has, in practice, been more about *privatisation* than cost-cutting. Privatisation is a broad and perhaps over-used term. However, if on the one hand, the involvement of the state in issues of public welfare takes many forms, including direct provision, subsidies and/or regulation (Flynn 1988), then privatisation might also be expected to take on a number of different forms, including a reduction of state involvement in any of these three areas (Kemp 1990). In practice, the result is that responsibility for some aspects of welfare provision have been transferred from the state, but largely without any reduction in the overall level of provision or state funding (Le Grand 1990).

It has been in Britain that some of the most radical privatisation policies have been implemented. Britain, under a Labour government in the late 1970s, was among the first to implement a strategy of welfare retrenchment (Flynn 1988). For the incoming Conservative governments, influenced by, indeed professing an open allegiance to, the ideas of the New Right – largely including a preference for the unfettered private market as the main and most efficient mechanism for the distribution of goods and services – the restructuring of welfare combined the desire to reduce public expenditure with an ideological imperative (Flynn 1988; Cole & Furbey 1994). Privatisation thus formed a central element of the restructuring of welfare in Britain during the 1980s and 1990s. But despite the rhetoric to the contrary, privatisation of the major welfare services has not, in Britain like most other European nations, reduced overall spending (Hills 1992).

An important feature of Britain's privatisation of welfare has, however, been the unevenness of its pace and extent and nature between the different services (Clarke & Langan 1993; Cole & Furbey 1994; Flynn 1988; Le Grand 1990). The National Health Service, for example, was left relatively untouched until 1987 and even then, although still suffering resource shortages, was not subject to any real reduction in funding. It was the social housing system that was at the 'leading edge' of welfare restructuring (Clapham *et al.* 1990). It is in fact the privatisation of state-subsidised housing provision that not only represents the Conservative governments '.... most successful attempt to replace the state with the market as the means of distributing goods and services' (Smith 1990a, p.757), but the only successful attempt to reduce public expenditure (Flynn 1988; Forrest & Murie 1988; Cole & Furbey 1994). Thus while the housing budget declined by a massive 60% between 1980-81 and 1995-96, over the same period, expenditure on health and the personal social services rose by 60%, on social security by 78% and on education by 30% in the UK as a whole (Wilcox 1996).

Cole and Furbey (1994) argue that the Thatcher government recognised that strategically, a fundamental transformation of the whole welfare state would be most easily achieved by an attack on the most vulnerable area of service provision, before moving on to the more entrenched services, the key institutions of the welfare state, such as the National Health Service and state education. State-subsidised housing, or more specifically, council housing, represented, for a number of reasons, that weak link in the chain of welfare services. Unlike the two services mentioned above, council housing has rarely represented anything other than a minority provision for the

working classes and most vulnerable sections of society and as such has not commanded the same level of support from the public at large as these other universal, and consequently, more popular, services (Cole & Furbey 1994; Flynn 1988; Forrest & Murie 1988). Moreover, the historical reliance on private contractors for the construction of council housing, largely financed by loans from the private money markets, means local authority housing has never been a fully deprivatised mode of provision (Kemp 1990). Taken together these factors afforded the Conservative governments the opportunity to radically restructure and privatise state-subsidised housing provision in Britain in such a way, and to such an extent, that makes the British case unique (Kenemy 1990; Doling 1994).

2.3 The privatisation of social rented housing

State intervention in the British housing system has traditionally included the provision and management of social (largely council, but also housing association) housing, the subsidisation of social sector rents and the provision of housing benefit for both public and private sector tenants. It has also included subsidies made available to home owners through mortgage interest tax relief and capital gains tax exemptions. Privatisation of the housing system over the last two decades has, therefore, also involved a range of policy initiatives, including relaxation of controls on rents in the private sector, reductions in the rate of mortgage interest tax relief and deregulation of the mortgage finance sector (Forrest 1993; Forrest & Murie 1988, 1994; Kemp 1990; Maclennan & Gibb 1990). What is of most interest here, however, is the privatisation of the social housing system. This itself has taken a number of different forms. It has, moreover, involved a range of policies which may have affected the capacity of the state-subsidised sector to continue its public health role (Smith 1990a; Smith, Alexander & Easterlow 1998; Smith & Mallinson 1997).

The social housing privatisation programme has included strategies that have been introduced to other areas of welfare provision – in particular the introduction of market principles, the development of the quasi-market and the separation of purchaser-provider functions. It has also, however, included some that have not been seen elsewhere in the welfare state. Taken together these policies have both reduced the role of the state in the direct provision of housing and transformed its involvement in issues of housing welfare more generally. Many of these changes were in place by

1991 (and the point in time that this thesis will largely be concerned with), with the policies being continued further into the 1990s.

2.3.1 The sale of council dwellings

One strategy unique to the housing field (and largely unique to this country) has been the direct privatisation of social, though largely council, housing. This has been achieved through its sale, since 1980, to sitting tenants and, since 1988, to alternative (non-local authority) landlords. The former policy reflected the Conservative governments' desire to promote home ownership, the latter their concern to see private renting as the normal mode of renting, and both a desire to reduce the council rented housing stock.

The extension of home ownership was a crucial element in the drive to establish the property-owning democracy, central to the New Right philosophy of self-reliance and independence (of the state). Home ownership, it is argued, provides the opportunity for a reduction in state interference in the housing system, promoting choice and providing the opportunity for personal wealth accumulation (Clapham *et al.* 1990; Malpass 1993).

From 1919 owner occupation and council renting had expanded together. However this changed from 1980 onwards. The growth of home ownership was sustained for many years this century by the transfer of dwellings from the private rented sector, but by the late 1970s private renting was reduced to little more than 10% of the housing stock and could no longer be relied upon to provide a substantial flow of dwellings suitable for transfer (Forrest & Murie 1988; Malpass 1993). Although a number of initiatives were introduced to promote owner occupation, including building-for-sale and shared ownership schemes, together with the deregulation of mortgage finance provision (making it more readily available) and the continued financial subsidy of home ownership through mortgage interest tax relief (though this was reduced on a number of occasions from 1988 onwards), a new source of dwellings for direct transfer was required. This led the government to embark upon what Forrest and Murie (1988, p.4) have called 'the most important element of the privatisation policy of the Thatcher government' – the sale of more than a million and a half council dwellings to sitting tenants (Wilcox 1996). 1980 saw the implementation of new legislation which gave large numbers of tenants of local housing authorities, new

towns and those housing associations not registered as charities, with a statutory right to buy their homes (Forrest & Murie 1988). For the first time, home ownership was to expand at the *expense* of council renting. Indeed Right to Buy sales of council homes to sitting tenants accounted for almost half of the growth in owner occupation throughout the 1980s.

Right to Buy sales peaked in 1982 and declined thereafter, prompting the Thatcher government to seek other means of maintaining the momentum of the privatisation programme. The Housing and Planning Act 1986 introduced higher discount entitlements for sitting tenants (reaching 60% for houses and 70% for flats) and sales increased temporarily following this, before declining once more. This was followed by the Housing Act 1988 introducing the idea of 'tenants' choice'. Those council tenants who could not afford (or did not wish) to purchase their homes were given the opportunity to transfer to another landlord of their own choice. The Act also introduced housing action trusts (HATs) – government agencies with the power to take over selected run-down local council estates to renovate, repair and improve them largely for subsequent privatisation (Ginsburg 1989; Kemp 1990; Forrest 1993; Cole & Furbey 1994).

Despite the success of Right to Buy, continuing council tenants have by no means, however, been convinced that they wish to transfer to another landlord (Ginsburg 1989; Forrest 1993). All six of the proposed HATs were abandoned or delayed in the face of tenant resistance, and although a limited number of re-styled ones have emerged, they have been at the local authorities' initiative and will revert back to local authority ownership (Forrest 1993). In practice the most important mechanism of transferring local authority stock has been the large-scale voluntary transfer (LSVT) – transfer initiated by the local authority itself, to newly formed local community housing associations (Ginsburg 1989; Kleinman 1993; Mullins *et al.* 1995). LSVTs can involve the transfer of a block of dwellings, an estate or even the entire housing stock. Although the 1985 Housing Act had made such transfers possible, the first transfer was not completed until late 1988. By the end of March 1991, however, fifteen local authorities in England had been involved in the large-scale voluntary transfer of their housing stock. This amounted to the transfer of 71,093 council dwellings out of local authority control. By March 1996, this had risen to fifty-one local authorities and a total of 223,417 dwellings and as a consequence, approximately 50 local authorities owned no housing (Wilcox 1996).

Further incentive to transfer has, moreover, been provided by the availability of government funding through the Estates Renewal Challenge Fund (ERCF) from December 1995 and the Housing Act 1996, of new landlords – particularly private local housing companies – willing to purchase poor quality urban local authority stock (Murie & Nevin 1997; DoE 1997). These companies would include local authority representatives on the controlling board, but these would have to be in the minority to be eligible for funding.

The sale of council houses to sitting tenants was not new, though the statutory right to buy and the provision of financial incentives to do so, was. What was also new, was the way in which sales were coupled with restrictions on local authority new build. Those dwellings sold to sitting tenants – more than had previously been sold in the entire history of council housing – have not been replaced as central government subsidy to local authorities has been slashed and restrictions on the spending of capital receipts from sales have been introduced. The housing budget had been more than halved by the beginning of this decade (Wilcox 1996), and it was central government subsidies to local housing authorities that were hit the hardest. As a result house-building by local authorities and new towns in England dwindled from 74310 in 1980 to 8, 051 in 1991 and this continued to decline to just 812 in 1995 (Wilcox 1996). What this has meant is that the stock of council dwellings in England has, for the first time in its history, declined in absolute terms – by over 1.5 million homes during the 1980s and 90s (Wilcox 1996).

Financial stringency also, undoubtedly encouraged many more authorities to 'voluntarily' dispose of some of what remained of their housing stock through large-scale transfer. The Local Government and Housing Act 1990 had, for instance, introduced an even stricter financial regime including a new subsidy system and a new system for the control of borrowing and capital expenditure (Hills 1991; Malpass & Warburton 1993). Thus although for some local authorities, particularly Conservative-controlled councils, LSVTs have provided the opportunity for the council to divest itself of a role – as a provider of housing – that, for ideological reasons, it does not wish to fulfil, the attractiveness of LSVT for many others relates to the ability of the new landlords to build, repair and retain their stock more easily (Audit Commission 1993; Kleinman 1993; Mullins *et al.* 1995). Since the cost of the backlog of repairs is deducted from the initial valuation of the housing stock, the new landlord will be in a better financial position to carry out these improvements. Local authorities can also choose to 'recycle' a proportion of the capital receipt from the transfer, once the

outstanding housing debt has been paid off (and since 1993, once government has taken 20% of the remaining proceeds) and give as a grant to the new landlord for new building. The new housing associations, unlike the transferring local authorities, were also allowed to take out loans in order to build new dwellings or renovate the existing stock. Moreover, although existing tenants retain their right to buy following transfer, new tenants will not have this statutory right. What this meant was that although local authorities themselves may have to relinquish their role as landlords, they would at least be in a position to ensure that the housing stock remained within the social rented sector, albeit managed more closely along market lines.

Reflecting the dual concern of the Conservatives to not only promote the private housing system, but to reduce the social housing sector, while both the Right to Buy and LSVT initiatives could have provided a housing investment opportunity for local authorities, instead they provided a fiscal opportunity for central government (Forrest & Murie 1988). Receipts from the sale and transfer of the best dwellings could, for instance, have been used to improve the remaining stock or build new dwellings. Instead, restrictions were imposed by the government on the use of capital receipts in order that they could be set against the public sector borrowing requirement (PSBR) (a 20% government levy on the receipts from transfer has also been in place since 1993) (Forrest & Murie 1988; Audit Commission 1993). Income from Right to Buy sales of council homes alone, in Britain as a whole – which by 1994/95 stood at £26 billion – was greater than for any other privatisation programme, and when combined with the receipts from the sale of housing association homes and the transfer of local authority dwellings, accounts for almost half of income from all the privatisation programmes combined (Wilcox 1996). Of course, these figures mask the costs incurred by central and local government in pursuing these strategies - including £24 billion worth of Right to Buy discounts and the increasing housing benefit costs to central government following transfer (see next).

2.3.2 Social sector rents, housing benefit and the quasi-market

A further important element of Conservative housing policy, particularly from the late 1980s, was to close the gap between social sector and market sector rents. In the local authority sector this was achieved through the effects of reducing the subsidy to local housing authorities and the 1989 Local Government and Housing Act which were to end the ability of local authorities to transfer funds in order to keep down rents

(Malpass 1993). Thus local authority rents in Britain as a whole rose by more than 60% in real terms during the 1980s (Hills 1991) and rose even more rapidly after 1990, though by 1995 the Government had recognised that further rises would provide little or no savings at all in public expenditure (DoE 1995). This is because rent rises to local authority tenants have largely been off-set by increased uptake of housing benefit.

This represents a direct shift in public spending in the council sector from general bricks and mortar subsidy to local authorities, to individual subsidy to their tenants. Thus while general subsidy in Britain was eliminated by 1994/95 and only a minority of councils in England, Scotland and Wales are now in receipt, an estimated 65% of council tenants are housing benefit claimants. This financial assistance totalled almost £5.3 billion in 1996/97 – a rise in real terms of nearly 300% since 1980/81 and now representing the largest part of housing expenditure (Wilcox 1996).

This is, moreover, part of a wider shift in housing finance as a whole, from direct provision by the state to 'subsidised individualism'. Thus one of the clearest pictures to emerge from Hills' (1991) detailed analysis of housing finance under the Conservative administrations is that although what is classed as the housing budget – which covers direct provision – declined, overall government expenditure on housing has not. Public spending has been redirected rather than cut, as the role of the state has changed, in a particularly ideological manner.

This redirection of housing expenditure was important to Conservative privatisation aims, not only because it made the provider role of local authorities increasingly difficult to sustain, but because it might further encourage tenants to purchase their homes or to change landlords. Increased rent levels would also make council housing more attractive to prospective investors (Kemp 1990).

The introduction of the 'quasi-market' into social housing provision, as in other areas of welfare, represented another important plank of the privatisation programme (Bramley 1993; Le Grand & Bartlett 1993). It was predicated on the availability of personal housing subsidy to social tenants who would themselves, as a result, be able to choose between a plurality of landlords. Unlike in those quasi-markets characteristic of other service sectors – such as education and the NHS – however, the competing service providers in the social housing quasi-market, were largely anticipated to come from the private sector, or what was termed in a politically euphemistic way, the

'independent' sector. According to the 1987 White Paper *Housing: the Government's Proposal* (DoE 1987) 'a more pluralist and more market-orientated system will ensure that [rented] housing supply can respond more flexibly to demand and will give the tenant wider choice over housing'. Plurality and choice was not about encouraging the existence of a thriving independent sector alongside an existing public (council) sector, rather it was about promoting the private rented sector at the expense of the public sector. This represented an end to the long consensus that council housing should be the 'normal' mode of rented provision (Kemp 1990), and signalled the transformation of social housing provision in this country. Local authorities were to relinquish their role as providers in order to become 'enablers' – enabling people to secure accommodation through the quasi-market of independent landlords (Goodlad 1994).

A number of measures to attract investors to the private rented sector – including deregulation of rents and tax incentives – were thus introduced (Kemp 1993). Even coupled with the transfer of local authority stock to new private landlords, however, these initiatives were unlikely to encourage the growth of the private rented sector sufficiently in order for it to replace local authorities as the main landlords. This latest housing privatisation strategy therefore came to depend on the expansion of the housing association sector, once it had been repositioned in the 'independent' sector.

Despite a history of being overshadowed by local authorities, housing associations were to become the main providers of new social rented housing – once the sector had been restructured along market lines. In 1974 housing associations had virtually been incorporated into the public sector through the introduction of a generous subsidy system based on the housing association grant (HAG) which covered on average 85% of the costs of building or rehabilitation schemes. Some specialised developments received 100% funding. The first phase of Conservative housing policy had left this funding regime largely untouched (Langstaff 1992), although large cuts were made in the budget of the Housing Corporation (the quasi-government agency responsible for promoting and regulating the housing association movement). It was clear, however, that an expansion in the role of housing associations would require a considerable increase in public expenditure and this was undesirable for the Conservatives. They therefore set about reforming the existing financial framework in such a way that allowed for this expansion without involving a rise in public expenditure, and at the same time shifted housing associations towards a more market-oriented ethos (Kemp 1990; Randolph 1993). Housing associations would continue to be classed as 'social'

landlords and would retain a responsibility to house those in 'need', but they would more closely resemble private landlords.

This 'reprivatisation' of the housing association sector (Randolph 1993) has involved the move to 'mixed finance'. From 1st April 1989 the housing association grant was set at a lower level than previously – typically about 75% – and the remaining costs were to be met by private loan finance (Randolph 1993). Today grant levels stand at below 50% (Joseph Rowntree Foundation 1996d) while over £8 billion of private lending for social housing has been levered in since 1988 (DoE 1997). What this has meant is that for a given amount of public expenditure, a higher level of housing output has been achieved. This combined with a planned tripling of the Housing Corporation's annual Approved Development Programme by the mid-1990s, it was anticipated, would result in the desired expansion and move to centre of the social housing stage of the housing association sector (Randolph 1993).

An important prerequisite for the attraction of private finance was the deregulation of housing association rents. Loan repayments would be more easily met if housing associations could use rents to raise the money. Previously housing association rents were set independently by the Rent Officer and usually at a level above council rents but below market rents. Thus the fair rent system was replaced for both new and re-lets with the 'affordable' rent system, allowing them to rise (Kearns 1992). In the immediate three-year period after deregulation, average affordable rents rose by three times the rate of general inflation and three times the rate of increase of those regulated fair rents that remained (Randolph 1993). Similarly, although existing tenants have usually been given rent ceiling guarantees for the period immediately following transfer to new local community housing associations, new tenants have not. Thus the rents on new lettings rose by up to 50% over the 4/5 years following the first transfers in 1988/89 (Audit Commission 1993). Moreover, rents of existing tenancies are expected to rise dramatically once the initial guarantee period is over (Mullins *et al.* 1995). Thus the shift from general bricks and mortar subsidy to individual subsidy is also characteristic of the privatisation of the housing association sector, since here too, more tenants are now eligible for housing benefit, and the average benefit paid to them has risen.

2.4 Privatising housing for health?

Taken together the range of Conservative housing policies reviewed above have changed the face of social housing provision in England (and Britain as a whole). They have had important implications for the size and nature of the state-subsidised housing stock, for the changing roles of local authorities and housing associations, and affordability in the social rented sector as a whole. In turn, these changes, it is argued here, may have had important consequences for the traditional public health function of the sector, and in particular, for the opportunities for people with health needs to gain access to housing suited to their needs in the sector through medical priority rehousing. The remainder of this chapter will be concerned with how the principle of social housing for health and social housing as health care may have been compromised by the privatisation of state-subsidised housing provision.

2.4.1 Decline of the local authority sector

We saw in Chapter One that the system of medical priority for rehousing is a housing for health strategy developed and operated largely by local housing authorities. It is one based on the allocation of council dwellings to households with health needs, and as such has depended on a role for local authorities as housing providers. Increasingly since 1980, this is a role that local authorities have seen diminish. For the first time in its history, the council housing stock has declined in absolute terms. Table 2.1 shows that the number of local authority dwellings in England was reduced by almost a quarter during the 1980s, from over 5 million in 1981 to under 4 million in 1991, and only 3.5 million in 1995. Thus, as waiting lists have increased in size, what this means is that people with health, mobility and care needs must increasingly compete with a range of other needs groups, particularly growing numbers of homeless people, for a declining stock of dwellings. As a result '...even chronic ill-health may no longer be sufficient to gain access to the public sector, let alone warrant transferring to a better dwelling within that sector' (Smith 1990a, p.757).

The effectiveness of medical priority schemes, moreover, has not only depended on the availability of local authority dwellings, but on access to suitable dwellings – usually the better parts of the housing stock. Another important point then is that the decline of the council sector relates not only to its reduced size but to a decline in the nature and quality of housing provided.

Table 2.1 Social rented housing stock in England

Thousands

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Local authority	5,061	4,886	4,763	4,670	4,584	4,504	4,403	4,254	4,081	3,944	3,880	3,810	3,741	3,663	3,601
Housing association	422	432	447	464	483	495	512	534	567	613	650	707	768	834	924
Total	5,483	5,318	5,210	5,134	5,067	4,999	4,915	4,788	4,648	4,557	4,530	4,517	4,509	4,497	4,525

Source: Wilcox (1996)

Right to Buy saw the sale of the most desirable properties – those in good condition, houses rather than flats and those in the most favourable locations within each district – leaving the poor condition houses and flats in unpopular locations, particularly the high rise estates built during the 1950s and 60s, to remain in the sector (Forrest & Murie 1988). In 1991, 40% of local authority dwellings were flats, compared with 24% of the total housing stock (DoE 1993). This combined with an increasing backlog of repairs, as the stock ages and design and construction faults of the 1950s/60s mass housing have come to light, meant that, despite a doubling in real terms of expenditure on renovation of council dwellings during the 1980s (Wilcox 1996), in 1991, over a quarter of local authority tenants were unhappy with the state of repair of their home and similar proportions were dissatisfied with its location (DoE 1993; Green *et al.* 1996). Thus the dwellings that remain under local authority ownership were, by the beginning of the decade and today, increasingly unsuitable for the project of housing for health.

This decline in both the size and quality of the council housing sector reflects its increasing residualisation since 1979. This process has also involved the concentration of low-income and benefit-dependent households into the sector in itself partly a result of the socioeconomic selectivity of sales whereby the more wealthy, employed, middle-aged and those in conventional family units were most likely to buy (Forrest & Murie 1988). Those who could not afford (or did not wish to purchase their poor condition homes) have remained dependent on the sector. Council housing has largely assumed a welfare role in providing a 'safety net' only, for those who for reasons of poverty, age or infirmity are unable to secure suitable accommodation in the private sector (Malpass & Murie 1982). The social and spatial polarisation of these groups into the most unpopular, increasingly run-down areas of (council) housing in the district, has not only led to the stigmatisation of this tenure, but also the emergence of social problems such as increased violence and crime (Clapham 1991). Housing managers increasingly question their ability to use the council housing allocation system to meet public health and community care aims and express concern that vulnerable people – often with health and/or support needs – are being housed in '.... run-down blocks of flats or estates which are threatening, insecure and even dangerous' (Arblaster *et al.* 1996, p.13).

What all this suggests is that '.... in terms of public health, the potential benefits of privileged access to state-subsidised renting are being eclipsed by the potential

contribution of council housing (through its poor condition and inadequate state of repair) to the development of illness and disease' (Smith 1990a, p.757). Indeed recent work in Glasgow by Ellaway and Macintyre (in press) suggests that housing tenure might be an important predictor of health status because being a local authority tenant exposes people to a range of housing stressors, including overcrowding, dampness, heating difficulties, and poor environmental conditions, in a way that they themselves relate to their (increased incidence of) experience of ill-health. Similarly, '.... if being part of the public sector is likely to condemn.... [those with care and support needs].... to living in poor housing conditions, in a deprived and deteriorating neighbourhood,.... and stigmatised by and cut off spatially and socially from people in other tenures – then the objectives of normalisation and community care are unlikely to be met' (Clapham 1991, p. 143).

2.4.2 Housing associations and the public health role

Although the local authority housing sector has witnessed a substantial decline in its housing stock, since 1989 this decline has been accompanied by a growth in the housing association sector. What this means, therefore, is that the reduced opportunities for people with health needs in the local authority sector may have been replaced by increased opportunities in the housing association sector. The housing association sector may have assumed the public health role formally assigned to the local authority sector and the capacity of the social sector as a whole to promote health through housing interventions may, therefore, have remained unchanged. There are, however, a number of reasons why, in practice, this might not have been the case by the early 1990s and why it might still not be the case today.

Firstly, although following the introduction of the mixed funding arrangements, the housing association sector did dramatically increase its rate of new build and for the first time since 1919, build more homes than did local authorities, the sector had not, by 1991, grown sufficiently to fill the gap left by a declining stock of council dwellings (see Table 2.1). Thus although the number of housing association dwellings in England increased from 422,000 in 1981 to 650,000 ten years later, and the ratio of local authority dwellings to housing association dwellings changed from 12:1 to 6:1, this still meant that the social rented stock as a whole had declined by almost one million dwellings over the same period (Wilcox 1996). Although this rate of decline

was reduced during the 1990s, by 1995 the stock of social sector dwellings was still almost 20% smaller than it had been in 1981.

Secondly, even if the housing association stock had grown sufficiently to fill the gap left by reduced local authority provision, there is evidence to suggest that people with health needs would still have experienced a decline in their social sector housing opportunities. Although housing associations are expected to house those in 'need', they are not statutorily obliged to take health and care needs into consideration when allocating dwellings, as local authorities are (see Chapter One). Early indications from the data set that will be employed in this thesis, are that they were not, at the beginning of the decade, as committed to the project of housing for health as the council sector traditionally has been (Smith & Mallinson 1997). While it seems likely that the allocations priorities of the new local community housing associations would, at least initially, remain consistent with those of the transferring local authority, more than nine years after the first large scale voluntary transfers took place, the allocation priorities remain unclear. Thus it is difficult to determine the opportunities for those with health and care needs among these housing associations, certainly as they become established in their own right.

Thirdly, although housing associations, including local community housing associations, may be in a better financial position to carry out repair work on their existing stock of dwellings, evidence has begun to emerge that the new funding regime is having detrimental effects on the quality of accommodation being built by the traditional associations. Two studies (Karn & Sheridan 1994; Walentowicz 1992) have found that space and design standards have fallen following the introduction of the 1988 Act. The average floor space per unit in new build schemes, for instance, fell by as much as 11% in the first year of mixed funding and by 1991/92 over two-thirds of new properties were built more than 5% below the Parker Morris space standard, compared with half in 1987/88. Cutbacks have also been made in the installation of cheaper, lower quality heating systems, and in safety design standards relating to such things as stair design and fire escape routes.

A further study (Page 1993) has also shown that an emphasis on producing large numbers of two- and three-bedroom general needs properties, as quickly and cheaply as possible in order to repay private loans, is leading to the development of large housing association estates built in peripheral locations with inadequate services and which are unpopular among tenants. Moreover, it is the most disadvantaged tenants

who are being housed there. In short, housing association estates may soon resemble the difficult-to-let, difficult-to-live-in estates that currently represent the worst parts of the local authority housing stock, and which, it was argued above, are unconducive to a high quality of life (Joseph Rowntree Foundation 1996b). And in a further important respect, the housing association sector may be following the local authority lead by increasingly housing a disadvantaged population so that the whole of the social rented sector has become the residual, stigmatising tenure. The average income of social housing tenants declined from almost three-quarters of the national average in 1981, to under half in 1990, for instance, and the respective figures in 1990 for council tenants and housing association tenants were 48% and 45% (Page 1993).

For a number of reasons then (and more will be described below), the housing association sector had not, by 1991, been able to offer a significant increase in housing opportunities for people with health needs. Some of these relate to the very mechanism that was to enable the expansion of the sector – mixed funding. Kleinman (1995, p. 35) refers to the 'underlying tension.... between the social goals which housing associations.... are expected to perform, and the market means by which they are expected to carry it out'. The idea of housing for need – including health need – may, it seems, be increasingly qualified by the principles of financial safety and limited risk (Harrison 1992; Pryke & Whitehead 1995; Warrington 1994).

2.4.3 Special needs housing provision

An important exception to the Conservative governments' concerted efforts, during the 1980s, towards ending the role of local authorities as landlords and as providers of new dwellings, was a continuing commitment to their housing of those people who were viewed as particularly deserving of state provision because of their 'special needs'. Indeed, the only growing part of the council sector was 'special needs' provision. Local authorities were encouraged to concentrate their reduced house-building activity on providing sheltered housing for the elderly and accommodation specially designed for the disabled, where the housing is often also packaged with care and support. At the same time some dwellings for the elderly and disabled were exempted from the Right to Buy legislation (Forrest & Murie 1988). Moreover, although the Housing Corporation budget was also slashed during the 1980s, housing associations were similarly given specific encouragement to develop such schemes and

continued to receive generous subsidy for the provision of special needs accommodation (Watson & Cooper 1992).

With the decline of the council sector and the decrease in new build of general needs housing by both local authorities and housing associations during the last decade, the provision of state-subsidised special needs accommodation was seen by the Conservative governments, not only as the only legitimate claim on scarce public housing resources generally, but by implication, as the only legitimate provision for those with medical and/or support needs (Smith 1989a,1990a; Clapham & Smith 1990; Smith & Mallinson 1997). It seems particularly pertinent, therefore, in the context of reduced general needs provision, to consider here the opportunities provided by social sector special needs provision for those with health needs.

While it is generally agreed that considerable benefits can accrue to those who successfully secure specialist housing (Clapham & Munro 1988; Clapham & Smith 1990; Clapham *et al.* 1990), there are a number of reasons why existing provision may not constitute an effective housing for health strategy, and why it does not provide a real alternative to the rehousing of people with health needs in general needs dwellings through medical priority schemes.

Firstly, special needs accommodation caters for only a limited number of health-related housing needs and only for a limited number of people who have these needs. For instance, although special needs schemes usually cater for the health problems associated with old age, for mobility problems, learning difficulties and mental health problems, they do not cater for a range of other medical conditions including, for instance, respiratory and infectious disease (Smith 1990a). This is despite the fact that they represent some of the most important reasons for incapacity to work, and as a consequence may prevent many from competing in the private housing market. Similarly, because eligibility for special needs accommodation is usually defined according to membership of a targeted group, rather than housing need, what this means is that those people with health needs who do not fall into these groups are excluded.

Secondly, the process of defining groups according to their 'special needs' in order to render them eligible for accommodation, can be stigmatising because it carries connotations of 'abnormality' and masks the fact that these housing needs are shared by many groups in society (Clapham & Smith 1990). Clearly this is not consistent

with community care aims of enabling people to live 'as normal a life as possible' (Social Secretary for Health 1989, p. 4). Moreover, provision has often taken the form of 'architecturally distinctive, often spatially segregated' (Smith 1989, p. 54) schemes, reinforcing this stigmatisation.

Thus although special needs housing schemes have tended to be seen as central to the community care strategy (Clapham 1991; Means 1996), increasingly user groups and individuals in need of community care have emphasised a preference for 'ordinary', mainstream housing with flexible support, if required (Arnold *et al.* 1993; Means 1996; Means & Smith 1996; Morris 1990,1994; Watson & Conway 1995). Arnold *et al.* (1993, pp. 25-26) argue that 'the community care needs of most people can be met by flexible support in ordinary housing.... [and].... that if suitable housing and support were available in the required amounts it seems unlikely that there would be any need to increase 'specialist' provision in forms of accommodation which are less-than-ordinary housing'. Indeed, an important point to emerge from the research is that for those who move into special needs accommodation, it is often the condition of the housing rather than the unique special features, or the availability of health and social care associated with this provision, rather than the accommodation itself, that is most important (Butler *et al.* 1983; Clapham & Munro 1988; Joseph Rowntree Foundation 1995a, 1996a; Means 1996). Thus difficulty in letting some parts of their specialist housing stock, particularly sheltered accommodation especially where facilities are shared and schemes are spatially segregated has become an increasingly common problem for most local authorities and housing associations (Joseph Rowntree Foundation 1995b; Means 1996).

Thirdly, notwithstanding the problems of finding accurate data on the stock of social sector special needs dwellings (see McCafferty 1994), it seems that the number is relatively small and that this type of accommodation represents only a small proportion (though varying from district to district) of the total social rented housing stock. The most important areas of provision by both local authorities and housing associations are for older people in particular and for the disabled. Using data from local authority HIP returns to the Department of Environment and a national survey of approximately 3,000 providers of specialist housing for older people in England, McCafferty (1994) estimates that in the early 1990s, the stock of local authority units of special needs accommodation for these two groups stood at approximately 550,000. Housing associations provided around 160,000 units. This represents less than one-sixth of the total local authority housing stock and a quarter of the housing association stock, and

less than one-fifth of all social rented dwellings. Moreover, this form of provision is now itself under increasing pressure as local authority output is declining and housing associations have been encouraged to take on a more general needs role. Funds allocated to special needs accommodation have not risen in line with the rest of the Housing Corporation's budget and the special needs management allowance introduced in 1991 limits the number of developments that funding will be made available for. Furthermore, as housing associations have become increasingly concerned with maximising new housing output, minimising risk and giving priority to housing families, special needs provision represents a high risk, expensive, supplementary role (Watson & Cooper 1992).

2.4.4 Affordability in the social housing sector

Despite the decline in respectability and desirability of social renting in the past two decades, rents have risen dramatically to produce an 'affordability crisis' in the sector (Bramley 1994; Kearns 1992). Local authority rents in England now stand at 13% of average male earnings, for instance, compared with 7% in 1980 (Wilcox 1996). Housing association fair rents represent 15% and assured rents almost 17%.

Although the numbers of social sector tenants eligible for housing benefit has also risen, the growth of housing benefit take-up has not stopped the proportion of income spent on rent for working tenants rising steadily. In particular, housing association rents have risen in some regions of the country to a level above average private sector rents (Joseph Rowntree Foundation 1995d, 1996c). These high levels, moreover, may similarly prove problematic for those tenants who are eligible for housing benefit. Concern has been expressed that local authorities may begin to refer high housing association rents – in the same way as private sector rents – to the Rent Officer to determine eligibility and restrict claims for housing benefit (Joseph Rowntree Foundation 1995d, 1996d).

Thus the social sector decreasingly represents a more affordable alternative to the private rented sector for those who are excluded from owner occupation, among whom we might expect to find people with health needs over represented.

2.4.5 The geography of social housing provision

A further important characteristic of the Conservative social housing privatisation programme which may have affected the sector's responsiveness to health and mobility needs, was its geographical unevenness. Drawing on a national local authority database of housing and health indicators that I have compiled (see Appendix I), I explore this issue here.

As a result of the autonomy afforded to local authorities, the supply of council housing has traditionally varied markedly both in its character and size (Forrest & Murie 1988). Generally, the metropolitan authorities have been the largest landlords. Council housing has historically been most important in the industrial conurbations of the North and West Midlands and inner London, while authorities with small council stocks have included coastal resorts and commuter areas surrounding the conurbations.

Geographical analyses of the decline of the council sector, particularly during the 1980s, have shown that the privatisation of council housing may have exaggerated these differences to produce 'local housing crises' in some areas (Kleinman 1988; Dunn *et al.* 1987; Barlow 1987; Hoggart 1995; Kleinman & Whitehead 1987). Forrest and Murie (1988) found, for instance, that council house sales did not proceed at the same rate throughout the country and were highest in the South East, East Midlands, Eastern and South West regions. They were lowest in London and the Northern regions. Variations were even more marked between local authorities. The general picture was one of high sales among Southern and particularly rural authorities, and lower among Northern urban districts and London boroughs (though there were exceptions). Sales were also found to be highest in areas where the council stock is predominantly houses, in relatively affluent areas, in Conservative-controlled authorities and in areas where high house prices prevent purchase normally. On the other hand, they have been lowest in districts with a high proportion of flatted accommodation, in poor and deprived areas and in Labour-controlled authorities. Moreover, similarly to the regional pattern, sales have tended to be highest in areas with traditionally low levels of council renting, accentuating existing differences (Dunn *et al.* 1987; Kleinman & Whitehead 1987; Hoggart 1995). The pattern of transfer of local authority housing stock has also been spatially variable. Transfers have largely been concentrated in the south of the country, in Conservative-controlled authorities with small housing stocks, largely in resort, growth and suburban areas in

a ring around Greater London (Audit Commission 1993; Mullins *et al.* 1995). It was for the first time in 1995/96 that the transfer programme included two metropolitan authorities – Walsall and Manchester – and these were only partial transfers (Murie & Nevin 1997).

Data I have extracted from local authority HIP1 returns to the Department of the Environment[1] show that between 1981 and 1991, the stock of council dwellings declined in absolute terms in all but thirteen of the 365 authorities in England for which data were available (data were missing for the Isles of Scilly). Fifteen authorities saw their stock decline by more than 95% – by 100% in three – as a result of the large-scale voluntary transfer of local authority stock to newly-formed housing associations. In only thirteen authorities, did the stock of dwellings increase (in three of these it doubled). Thus, on average, local authorities saw their housing stock diminish by 22%. Since the number of households increased at the same time in all but one authority (Tewkesbury), this meant that the supply of council dwellings, as measured by the number of dwellings per 1000 households[2], was lower in 1991 than in 1981 in all but eight authorities.

But this supply, as we would expect, varied markedly. The fifteen authorities that had voluntarily transferred all or most of their stock, as we would expect, had no, or negligible numbers of, dwellings left under council ownership. At the other end of the scale, Tower Hamlets had a supply of 664 council dwellings per 1000 households. Similarly, the condition of the housing stock differed between local authorities. Thus while as many as 148 (out of 344 authorities for which data were available) reported that more than half their stock in 1991 was unfit[3] or in need of renovation[4] , with 35

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[1] Local housing authorities provide information annually to the Department of the Environment in Housing Investment Programme housing needs appraisal (HIP1) forms. These provide the most comprehensive and complete data available on the local housing stock, of all tenures, although data are not consistently received from each authority and returns can be incomplete. These data are not published but were provided, on request, by the DoE specially for this study. This information is included in the national local authority database of housing and health indicators I have compiled (see Appendix I).

[2] Housing supply could also be measured by calculating the number of lettings per 1000 households. Local authority lettings have not declined to the same extent as has the stock of dwellings (Wilcox 1996), and as such show a smaller decline in the supply. It was felt, however, that the (relative) size and quality of the housing stock reflects more accurately the options open to housing managers in meeting housing need. As such, the supply of dwellings measured in this way, together with its quality, provide a better indicator of the availability of suitable accommodation for people with health needs.

[3] Dwellings defined as unfit in Part XVII of the Housing Act 1985 as amended by Schedule 9 of the Local Government & Housing Act 1989.

[4] Not unfit but unsatisfactory and in need of repair.

saying that as much as 90% was in such poor condition, in 77 authorities less than 10% of dwellings were in this category.

The literature suggests, moreover, that not only has the privatisation of council housing been spatially uneven in its impact, but so too, since 1988, has that of the housing association sector. The switch to mixed funding has not only begun to break down the more uniform rent patterns produced under the fair rent system (Randolph 1993), for instance, but the need to minimise risk also appears to be changing the geography of provision (Pryke & Whitehead 1995; Randolph 1993). Housing associations are choosing to shift their development activities from inner city areas to more rural areas where building costs are cheaper and risks lower (Randolph 1993; Walentowicz 1992) and thus '... the new [funding] system contains inherent conflict for associations – for example between their social priorities in terms of meeting needs in specific areas, and their commercial priorities such as minimising risk'. Concern has been expressed that this might amount to a reduction in new provision in those areas of greatest housing need (Harrison 1992; Randolph 1993).

My analysis suggests similarly that the supply of housing association dwellings varied markedly from one local authority to another in 1991 (data were again missing for the Isles of Scilly). Two authorities had no dwellings in this sector, while the maximum supply was 179 per 1000 households (in Tonbridge). Most of those authorities that had transferred their council stock by 1991, were now, as we would expect, among those districts with the highest housing association supply. The average supply of housing association dwellings, however, stood at just 27, and thus was considerably less than that for local housing authorities.

The change in housing association stock size had similarly been uneven between 1981 and 1991, just as it had for local authorities. In thirty four authorities the total housing association stock had declined – presumably the result of Right to Buy – but in the remaining districts it had increased (data were missing for the Isles of Scilly and Stoke-on-Trent). Most saw their stock more than double; thirteen saw it increase by more than ten times. The housing association sector, moreover, generally expanded most in those areas where local authority stock decline was greatest (reflected in a Pearson Correlation Coefficient of -0.45 where $p < 0.01$ for the 364 authorities for which data was available), though the relationship was not perfect reflecting the influence of factors other than a concern to fill the gap left by the local authority sector.

But despite this dramatic increase in housing association dwellings in most areas, because the housing stock had been relatively small (in comparison with council dwellings) at the beginning of the decade, the absolute increase in dwellings did not off-set the decline in local authority dwellings over the same period, and thus the total stock of social rented dwellings declined in all but 21 of the 364 authorities for which data were available. The average decline was 15%, but once again this change was spatially uneven with 39 authorities losing more than a quarter of their housing stock (Rochester saw a 95% decrease) and three (Tower Hamlets, West Lancashire and Redditch) seeing their stock double. In 1991 the supply of social rented housing was also, therefore, uneven. Since local authorities remained the most important social landlords in most areas, the pattern of social sector supply closely reflected that of the local authority sector. The composition of the social stock, in terms of who provided it, did also, however, vary to an extent. In those areas where the local authority had been involved in the large-scale transfer of its dwellings, as we might expect, the housing association sector dominated, though this was also true in the London Borough of Kensington and Chelsea where no transfer had occurred.

This geographical unevenness in the decline and subsequent availability of council housing, of social rented housing as a whole and the changing nature of its provision, may be important to this discussion, since given the wealth of evidence suggesting the existence of spatial variations in health at the inter- and intra- regional scales in England (see for example Dorling 1997; Townsend *et al.* 1988; Whitehead 1992), we might also expect levels of demand for social rented housing on health grounds to similarly vary.

For the first time since 1911, the 1991 Census included a health-related question. This asked for an indication of '.... any long-term illness, health problem or handicap which limits.... daily activities or the work.... [a person].... can do'. Since this information is readily available at a number of spatial scales, it is thought to provide an important predictor of the difference in need for health and other social services between geographical areas (Charlton *et al.* 1994; Martin *et al.* 1995). It was argued in Chapter One that the social rented housing sector represents both a social and health care service. Local authority household rates of limiting long-term illness might therefore represent a useful indicator of the need or potential demand for medical priority rehousing in that area[1].

[1]This information is contained within my local authority housing and health database. See Appendix I

In England as a whole, 24% of households contained at least one person with limiting long-term illness at the time of the Census (OPCS 1994). This figure, however, was found to vary considerably throughout the country (Charlton *et al.* 1994). Table 2.2 lists the 10 districts in England with the highest and lowest proportions of households with a member suffering from a limiting long term illness (LLTI). It also provides information on the supply of social sector dwellings in these authorities. It shows that, overall, those authorities with the highest rates of illness also had a greater supply of both local authority dwellings and social sector dwellings in 1991. Indeed, a statistically significant ($p< 0.05$) positive correlation was found to exist between both council housing supply and household rate of limiting long-term illness (Pearson Correlation Coefficient = 0.46) and social housing supply and household rate of limiting long-term illness (Pearson Correlation Coefficient = 0.44). Since meeting health need is an important objective of the social housing system, the geographical relationship between social housing supply and demand on health grounds is not as strong as we might expect (or hope). Clearly other factors account for the spatial distribution of social housing. Table 2.2 shows that although those authorities where we might expect demand for rehousing on health grounds to be highest do have the greatest supply of social housing, and those where we would expect to be least, have among the lowest, the relationship is not perfect and some authorities do not fit the general pattern (see, for example, Stoke-on-Trent and Kensington and Chelsea).

What all this means is that within a context of reduced opportunities in most areas, social sector housing was not always most available, nor suitable, in 1991, in those areas where we might expect demand on health grounds to have been greatest. Moreover, the data suggest that this mismatch may have been exacerbated by the geographical unevenness of the privatisation of social housing provision during the previous decade. Table 2.2 shows that those authorities with the greatest potential demand for rehousing on health grounds (as measured by the household rate of limiting long-term illness) saw a slightly larger average decline in the size of their social rented housing stock than those authorities with the smallest potential demand. But, of particular interest, the data show that those areas with a low supply of social housing relative to level of health need in 1991 had, on the whole, seen their housing stock decline to a greater extent over the previous ten years than had those authorities with a relatively high supply of housing in 1991. For instance, authorities with above-average household rates of long-term limiting illness but below-average supplies of social housing in 1991, had experienced a mean decline of their social stock 10%

Table 2.2 Household rates of limiting long-term illness and supply of social housing in England, 1991.

Local authority (English region[1])	LLTI[2] (% households)	LA housing supply[3]	LA housing unfit or in need of renovation[4] (%)	HA housing supply[3]	Total social housing supply[3]	Change in social housing supply 4/81-4/91 (%)
Highest rates						
Easington (N)	41.7	414	43	44	458	-21
Barnsley (Y&H)	34.6	320	62	11	332	-20
Knowsley (NW)	33.5	412	99	29	441	-39
Wear Valley (N)	33.4	274	81	49	324	-18
Derwentside (N)	33.2	321	42	22	343	-19
Wansbeck (N)	33.1	328	39	15	342	-18
Sedgefield (N)	32.9	370	86	31	401	-32
Sunderland (N)	32.9	413	100	36	449	-7
Liverpool (NW)	32.6	324	84	124	447	-9
Stok-on-Trent (WM)	32.6	260	53	32	292	(missing)
Lowest rates						
Bas'stoke/Deane (SE)	17.4	187	14	21	208	-26
Elmbridge (SE)	17.4	113	58	15	128	-18
Bracknell (SE)	16.6	234	11	29	263	-27
East Herts (EA)	16.6	170	50	3	173	-24
Newbury (SE)	16.5	4	5	151	155	-15
City (SE)	16.0	81	0	0	81	(missing)
Ken/Chelsea (SE)	15.9	118	42	176	294	+10
Hart (SE)	15.6	82	4	8	90	-20
Surrey Heath (SE)	15.2	105	69	3	108	-28
Wokingham (SE)	14.2	66	22	12	78	-9
England[5]	24.1	182	44	27	209	-15

Notes:
1. English regions: N=Northern; Y&H=Yorkshire and Humberside; NW=North West; WM=West Midlands; SE=South East (including Greater London); EA=East Anglia.
2. Percentage of households with one member or more suffering from limiting long term illness.
3. Housing supply is the number of dwellings per 1000 households.
4. Dwellings defined as unfit in Part XVII of the Housing Act 1985 as amended by Schedule 9 of the Local Government & Housing Act 1989, or not unfit but unsatisfactory and in need of renovation.
5. Data for England, excluding limiting long-term illness, are based on average figures for all authorities for which data were available through the DoE HIP1 returns.

Sources:
DoE 1991 HIP1 returns, OPCS 1994.

greater over the previous ten years, than that experienced by those authorities with below-average rates of limiting long-term illness but above-average housing supplies.

2.5 Conclusion

There are, then, a range of indications that by the beginning of the present decade, the availability, quality, character, affordability and location of the social rented housing sector had changed sufficiently to compromise the ideal of housing for health and housing as health care which had been a centre piece of allocations policy for more than 25 years. It is in this context that the thesis will go on to explore the opportunities – including the geography of opportunity – available, through medical priority rehousing, to people with health and mobility needs. Of course, a number of factors mediate the relationship between the experience of ill-health and the demand for medical priority rehousing. These include the suitability of current housing, the desire or otherwise to move home, the affordability and availability of other housing alternatives, as well as an awareness of the existence of medical rehousing schemes. Moreover, a range of other factors mediate the relationship between an uneven supply of state-subsidised housing and demand on health grounds, including demand from a range of other groups in housing need, suitability of the available accommodation and a range of rationing measures implemented by social housing providers in the bid to match their supply of dwellings to demand. The following chapters will explore many of these issues, but my point here is that, notwithstanding the existence of these intermediary factors, it seems unlikely that, in the early 1990s, need for housing on health grounds arose at the same time and place as the supply of suitable social sector accommodation.

3

SOCIAL HOUSING AND HEALTH NEED: AN INTRODUCTION TO MEDICAL PRIORITY FOR REHOUSING (MPR).

3.1 The concept of 'need'

In the market place goods and services are distributed simply and relatively unproblematically according to consumers' ability to pay. In the welfare sector the price mechanism is suspended as a distributive device. Goods and services are allocated instead, in principle at least, according to need (George & Wilding 1976). The basis for allocating welfare resources according to need – the principle upon which the whole welfare state has, for more than fifty years, been predicated – is the belief that needs are universal, objective and can be measured empirically by professionally-qualified experts (Foster 1983; Plant 1991). In this way needs and wants or desires can be easily differentiated. In recent decades the concept of need as a meaningful criterion on which to base the distribution of welfare goods and services has been questioned by academics who highlight the fact that it is in fact a relative concept whose definition rests partly on value judgements. Political commentators on the Right have argued further that the market, based on the concept of supply and demand, is a more efficient and effective means of distributing goods and services than the state on the basis of need (Foster 1983). Notwithstanding these criticisms, need remains a key distributive mechanism for social and welfare services, even as these are restructured along market lines. The principle of making welfare transfers in cash or kind according to need is one to which governments and politicians remain committed, even if definitions of need are drawn ever more tightly.

As an integral element of the welfare state, the social housing system is concerned with meeting *housing* need (Clapham & Kintrea 1987; Parker *et al.* 1992; Spicker

1987). Although local authorities have received both advice and statutory guidelines from central government on housing allocation procedures (Foster 1983), these have often been too vague to map directly onto allocations systems (Spicker 1987). Through a series of housing acts, local authorities have been required to meet local housing needs and to give reasonable preference in their housing queues and allocations systems to certain 'needy' groups such as the elderly, those with dependent children and those living in insanitary, overcrowded or other unsatisfactory housing conditions. Since 1977, they have also been statutorily obliged to find permanent accommodation, though not necessarily their own, for certain groups of homeless people (this duty was modified in the Housing Act 1996, but reintroduced following the election of a Labour government in 1997). But local authorities have largely been free to determine for themselves who falls into these 'needy' categories. So, notwithstanding their statutory obligations, councils have been afforded a great deal of autonomy in both defining housing need and in determining their own priorities (Spicker 1987). Housing associations have a statutory duty to assist local authorities to meet their responsibility towards the homeless and are expected by their regulatory body, the Housing Corporation, to house those in need, though they are largely free to choose which housing needs they wish to meet. Traditionally this has led them to meet specific needs such as those of older people and those with 'special' needs (Best 1991), though in recent years they have been encouraged, as the new main providers of social housing, to meet a wider range of needs.

3.1.1 Medical need as housing need

From time to time legislation has defined (some of) those with health needs as one group in housing need. For instance, together, the Housing Acts 1957, 1985 and 1996 have required local authorities to give priority to those living in insanitary, overcrowded or other unsatisfactory living conditions (all of which could refer to 'unhealthy' homes) and to those with a need for settled accommodation on medical grounds. Local authorities were similarly required by the Housing Act 1985 to give priority to those homeless people whose vulnerability is related to age, 'mental illness or handicap', physical disease, or other 'special' reason (which case law has determined can be related to ill-health). The Chronically Sick and Disabled Persons Act (1970) also placed an obligation on local housing authorities to take account of disabled people's housing needs, and the Housing Act 1996 requires them to give priority consideration to households consisting of or including someone with a

particular need for settled accommodation on medical or welfare grounds. These requirements do not, however, constitute comprehensive guidance on the incorporation of health-related housing needs into council housing allocation systems, let alone those of housing associations.

Despite this, the national study of social housing provision for people with health needs in England employed here, found that medical need is widely recognised as a valid indicator of housing need in the social housing system in the 1990s. Thus all the local authorities discussed in this thesis had in place some system of assigning priority in their housing queues on health grounds. 96% (112/117) of these had specifically *medical* priority systems, the remaining authorities had 'social' or 'special needs' priority systems which included health needs. Similarly, almost 90% (69/78) of those housing associations with general needs housing stock – or three quarters of all associations surveyed – had procedures for incorporating health needs into their housing allocations systems[1] . Thus medical priority for rehousing represents, in the 1990s, an important tool and key aspect of social housing management based on the principle of allocation according to need.

3.1.2 Need and welfare rationing

Just as the concept and definition of need is itself a complex issue, distributing welfare resources on this basis can similarly be a problematic task. Unlike in the private market where supply and demand are effectively kept in equilibrium by the price mechanism, in the welfare sector demand is not limited by ability to pay and needs are potentially infinite. In this situation, if demand outstrips supply, as it nearly always will do, the tendency is not for prices to rise, thereby reducing demand, but for the service to be rationed.

A wide literature has built up on the issue of welfare rationing. This has highlighted a range of strategies including formal and informal rules and regulations (Foster 1983; Scrivens 1979), overt and covert actions and procedures (Rees 1972) and explicit and implicit methods (Parker 1975), all with the aim of matching available resources to demand. Those attempting to contain demand – termed 'primary' rationing strategies

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[1] A total of 93 housing associations were surveyed, but only 78 of these had any general needs dwellings. Of these associations, 69 award priority in the housing queues on the grounds of ill-health and/or disability. The thesis will largely be concerned with these 69 associations only, unless otherwise stated. See Appendix I for more detail.

(Scrivens 1979, 1982) – have been found to include the strict definition of what constitutes need, and/or the prioritisation of needs over others (Williams 1985). Most legitimately, this includes deciding who is in most need and who is in lesser need, thereby prioritising different groups of need, so that those in *greatest* need receive assistance. However, differentiating between those in need can also involve making decisions on who will receive assistance on grounds other than need. In particular, the issues of suitability and desert have been shown to increasingly impinge on allocations decisions when resource shortages are experienced (Foster 1983; Parker 1975; Scrivens 1982; Williams 1985).

Where accepted need still outstrips supply, even after the regulation of demand at this early stage in the process, a variety of other rationing measures are implemented, in a further attempt to match demand and supply. These have been termed 'secondary' and 'tertiary' rationing procedures (Scrivens 1979, 1982). Secondary rationing includes the queuing of claimants in waiting lists until resources become available. While those in greatest need will usually, at least officially, be placed at the top of the queue, factors other than need can again affect an individual's position and the time they must wait to receive a service. Tertiary rationing determines who will receive what kind and quality of assistance.

In the field of housing, primary rationing determines who is eligible to enter the waiting and transfer lists – who may queue for state-subsidised housing. Secondary rationing procedures determine how they queue. In the context of a stock of housing of uneven character and quality, particularly in the local authority sector, tertiary rationing procedures determine who will be allocated *what* housing (Clapham & Kintrea 1987; English 1987; Foster 1983).

It seems likely that in contexts where demand greatly exceeds supply, allocation according to need might more closely represent political rhetoric than practical outcome. It suggests that greater need will not always secure assistance over lesser need, nor that equal needs will receive equal assistance. Since the 1970s a substantial body of research has built up on the problems of attempting to operationalise the concept of *housing* need fairly. This has shown how the interaction of housing constraints, the role of the applicant, housing management goals and a range of primary, secondary and tertiary rationing procedures, in addition to need, determine housing outcomes. The result is that some 'needy', but often deemed 'undeserving' individuals and groups – including low income groups, the homeless, single parent

families and ethnic groups can be disadvantaged in the housing allocation system, particularly in terms of the quality of housing they receive (Clapham & Kintrea 1986; Henderson & Karn 1984; Jeffers & Hoggart 1996; Lidstone 1994; Robinson 1998; Watson 1986; Watson & Austerberry 1986). It is in this context that this thesis is largely concerned with how those with health problems as another needy – but a relatively privileged – group fare in these social housing allocation systems.

3.2 Medical priority in the 1990s

The practice and value of allocating housing according to specifically *medical* need and the experience of those with health needs in the social housing system has received relatively little attention. Smith (1990a) suggests that, as an unambiguously 'deserving' group in society, the social housing system has popularly attempted to place those with health needs high in the housing queues and the assumption among researchers and policy makers is that this is just what it has done. In the context of a restructured social housing sector, however, when those with health-related housing needs must compete with a range of other needs groups, particularly the homeless, there is at least a question to be asked about how those we set out to help fare in practice.

The capacity of the social housing system to operationalise the concept of housing for health depends on the ability and effectiveness of medical priority systems throughout the country to identify, award priority to, and secure suitable accommodation for, those whose housing needs relate to their health problems. However, a number of local studies, largely conducted prior to the post-1980 decline in the local authority housing stock, found that only limited numbers of those securing medical priority are rehoused in the sector (CRE 1984a, 1984b; Cole & Farries 1986; Gardner & Troop 1981; Howells 1984; Maclennan *et al.* 1983). The local authority survey being used in this thesis shows, moreover, that during the 1980s, the stock of almost all the local authorities shrank – by a factor of between three and forty per cent. Just three authorities experienced an increase in the size of their housing stock. Against this background, the majority of authorities surveyed also saw an increase in the number of medical priority applications: 29/117, 25% experienced a large increase, 39/117, 33% a moderate increase. Just two reported a decrease in demand, though even these authorities simultaneously experienced a decline in their housing stock of one-fifth. In the remaining authorities, demand remained constant. As many as two-thirds (81/117)

of local authorities in England also say, therefore, that the demand for medical priority in their district outstrips the supply of suitable accommodation owned by the authority (Smith & Mallinson 1997). This suggests, as others have argued, that the practice of awarding priority in the social housing queues – in particular, the council housing queues – on the basis of medical need is under pressure and that the potential for the system to promote health is therefore increasingly limited (Bickler 1988; Connelly & Roderick 1991; Muir Gray 1990; Parsons 1987).

It seems unlikely, as argued in Chapter Two, moreover, that the housing association sector has been able or willing to assume the public health role traditionally fulfilled by local authorities. Despite the decline of the local authority housing stock and, after 1988, the simultaneous increase, albeit limited, of housing association provision, people with health needs do not themselves appear to see their social housing opportunities as now lying largely in this latter sector. Smith and Mallinson (1997a) found that among those surveyed in the national study, more local authorities than housing associations reported an increase in demand for medical priority rehousing. And, moreover, chances of securing a move on health grounds for those who do approach a local housing association may be similarly limited. Three-quarters (52/69) of housing associations that award priority in their housing queues on medical grounds reported that demand for medical priority rehousing outstrips their supply of suitable housing.

A further challenge to the future of medical priority comes from the medically-qualified professionals – usually general practitioners and/or public health physicians – whose expertise has hitherto been called upon in the assessment of medical need and apportionment of medical priority in the council housing queues. This task is officially the responsibility of housing managers, but in practice local authority housing managers and health professionals have worked closely in developing and operationalising medical priority systems. Housing managers have relied on the clinical judgements of medically-qualified advisers to determine who should be awarded medical priority and the type of housing they should be allocated (Easterlow & Smith 1997). In the 1990s, health professionals continue to work closely with housing managers in the implementation of medical priority for rehousing. The national surveys employed here show that fully, 97% (114/117) of local authorities and 88% (61/69) of those housing associations operating such a system consulted health professionals in the decision concerning the award of medical priority. In the past, those health professionals involved in providing medical assessments have

highlighted the practical problems associated with recognising and prioritising a range of housing-related diseases and health problems, and with achieving consistency between cases (Aston & Gordon 1981; Bakhshi 1986; Muir Gray & Yarnell 1979; Maclennan *et al.* 1983; Muir Gray 1978). In recent years, as the capacity of the social housing system to employ housing as a health intervention appears to have declined still further, the medical profession has begun to question its role in the medical priority system more generally. Those involved in providing the clinical information on which medical needs assessments are based doubt the value of their input (Kohli 1986; Stone 1991), and public health professionals carrying out these assessments have begun to argue that the rationing of a health intervention in this way, may be an unsuitable role for their profession (Connelly & Roderick 1991; Muir Gray 1990; Parsons 1987; Roderick *et al.* 1991). Thus, at a time when resource shortages make the need to ration more important, housing managers are faced with the threat of health professionals ending their involvement in the identification and prioritisation of health-related housing needs upon which the medical priority system depends.

A third issue is that there has, in the past, been little hard evidence to suggest that rehousing is an effective health intervention even for those who are successful in securing a move (Austin *et al.* 1994; Cole & Farries 1986). Some – perhaps even most – people's health needs, it has been argued, are best served in their existing homes (DoE 1995; Leather & Mackintosh 1993a; Mackintosh & Leather 1992; Maclennan *et al.* 1983; Secretary of State for Health 1989). In this light, and at a time when, in the context of a declining social rented housing stock and of community care, the idea of moving on is increasingly eclipsed by the concept of staying put, it is easy to argue that the resources devoted to medical rehousing might be better and more effectively invested into the rehabilitation and adaptation of the existing home (Cole & Farries 1986; Easterlow & Smith 1997).

A fourth key issue concerning the efficacy of medical priority, is the possible existence of geographical variations in both the operation and effectiveness of local authority schemes, and thus, by implication, the experience of, and opportunities available to, people with health needs in the social housing system (Connelly & Roderick 1991; Parsons 1987; Thomas & Yarnell 1978). The autonomy afforded to local authorities in the strategic management of their housing stock, together with the spatial unevenness in the capacity of the council housing system to accommodate those with health needs (see Chapter Two), suggests that not only do housing managers incorporate medical needs into their allocations systems differently, and vary in their recognition of which

medical needs are housing-relevant, but the pressures to ration the service through a range of means are greater in some areas than others. We might similarly expect this to be true of an autonomous and geographically uneven housing association sector. As a consequence, the opportunities for people with health needs to secure suitable housing through a medical priority system might vary as much according to where they live as to their need for rehousing.

3.3 Medical priority and the study aims

The next three chapters, in light of the issues discussed above, will be concerned with the capacity of the social housing system to continue promoting good health and well-being through the allocation of housing on the basis of medical need, in the 1990s. As such I will necessarily explore and describe the operation of medical priority rehousing schemes throughout England. I will also consider what this means in terms of the social housing opportunities available to those with health and mobility problems, throughout the country. It is in this light that Chapter Seven will turn its attention to the opportunities available to those with health needs in that part of the housing system that is not geared to the principle of need and as such does not allocate resources on the basis of medical or any other housing need – the private housing system.

Chapters Four to Six will be based on the secondary analysis of the quantitative surveys and case study visits conducted in England in the early 1990s (see Appendix I). Recent contact with the case study authorities has also allowed me to update some of this information. Together these data provide the most comprehensive information on the system of medical priority rehousing to date. They include the opinions on, and experiences of, medical priority rehousing schemes according to both those operating and rationing medical priority – social housing managers (both local authority and housing association) and local authority medical advisers – and those applying for rehousing on the grounds of medical need.

Hitherto the data sets have largely been analysed separately and have not been disaggregated below the national scale. They can, however, be linked together and analysed at the scale of the local authority district. The survey findings can also be linked to a local authority data set that I have compiled (and already employed in Chapter Two), showing changes in the social rented housing stock and its current characteristics as well as demographic characteristics of the local populations (see

Appendix I). The following chapters will both disaggregate and link these data sets in order to establish how they interact and to give a detailed understanding of how and why medical priority schemes operate the way they do, how and why the award of medical priority is rationed, and how, as a consequence, people with health needs fare in a restructured social housing system that in principle at least, is committed to meeting their related housing needs.

Reflecting the nature of the data available, the thesis will necessarily concentrate on the distribution of social sector homes according to medical need by the local authority sector, although where appropriate, information concerning the housing association sector will also be included. This will especially be the case in those areas where housing association dwellings represent a significant proportion of all social sector dwellings. It is important to point out here, however, that despite the decline in the size of the local authority housing stock since 1980, and from 1988 onwards, the simultaneous increase in the housing association stock, local authorities remained the largest social sector landlords at the time of the surveys and do so today. Moreover, a new Labour government has expressed a commitment to reversing the decline of the local authority sector experienced over the past eighteen years. As a consequence, social housing opportunities for those with health needs today and in the near future, remain greatest in the local authority sector, a point that, as we saw, they themselves appear to recognise.

Chapters Four and Five will be concerned with the primary rationing of medical priority. Chapter Four will look at the formal medical needs assessment process and in particular the role of health professionals in this. It will explore the opinions of both health advisers and housing managers on the usefulness and effectiveness of this medical input. Chapter Five will be concerned with other, formal and informal, overt and covert, intentional and unintentional, rationing strategies that determine who will and who will not have their health needs formally assessed, as well as who will successfully secure a medical priority award and be allowed to join the housing queues on health grounds. Chapter Six will look at strategies of secondary and tertiary rationing, including the operation and organisation of waiting lists, and the procedures for allocating an uneven housing stock among those with medical priority. The primary aim of the next few chapters is thus to explore not only the problems of operationalising the concept of medically-related housing need in the social housing sector, particularly the council housing system, but to determine and describe who gets what, where and with what health effect, as well as how and why.

4

HOUSING MANAGERS AND HEALTH PROFESSIONALS: A HEALTHY ALLIANCE?

4.1 The 'healthy alliance'

Current health policy suggests that there are a range of social and environmental determinants of both good and bad health and that the activities of a range of agencies and organisations (including government) impinge on public health (Secretary of State for Health 1992; 1998). The responsibility for promoting the nation's health and well-being should fall, therefore, not just to the National Health Service (NHS). In particular, a range of organisations in the private, public and voluntary sectors are acknowledged as having a role to play in providing 'healthy' living, work, school and home environments. A new, more specialised role is, therefore, envisaged for the NHS in extending the right to health to the British public. This involves forging partnerships or 'healthy alliances' with these organisations.

Although the idea of the 'healthy alliance' may appear to be a new innovation, in fact, as we saw in Chapter One, one such partnership has existed for more than 100 years – the alliance of health servicing with housing policy. Today the most widespread example of joint working between these groups in the project of housing for health is in the administration of medical priority rehousing (Easterlow & Smith 1997; Goss & Kent 1995; Roderick *et al.* 1991; Smith *et al.* 1994). Health professionals work closely with local authority housing managers in determining who is in medical need and who should be allocated housing on these grounds. Moreover, despite the doubts voiced by some involved in this alliance (see later), it has also been found to represent an example of relatively unproblematic, indeed, good, practice in collaborative activity between the health and housing professions (Goss & Kent 1995).

Despite its long history we know little about this alliance, about the role and relevance of health professionals in the allocation of social housing on medical grounds, nor how the alliance works in practice. Prior to the national medical priority study employed here, the existing literature on the subject was limited and related largely to the opinions of a few health professionals in single housing departments. It did, however, point to a dissatisfaction on their part, and calls for an end to their involvement in housing management decisions.

The medical priority study includes national surveys of both housing managers and their medical advisers – those health professionals offering advice to the housing department on medical priority decisions, together with an observation of their roles through case study visits in nine local authorities. So far these sources have been analysed separately (see Easterlow & Smith 1997; Smith & Hill 1992; Smith *et al.* 1994). Here I seek to bring together these data sources in order to provide a comprehensive account of the (formal) medical needs assessment procedure in English local authority housing departments. This will also allow me to explore the experience of both professions involved in the implementation of medical priority rehousing, and their opinions on the usefulness and effectiveness of medical input. In light of an earlier finding that the form of this alliance differs widely throughout England (Smith *et al.* 1994), it will also consider how these views vary according to the various models of collaboration currently in use. Thus the analysis will establish whether some health and housing alliances work better than others.

The findings of this part of the study may be important for a number of reasons. Firstly, since the purpose of this alliance is to determine who is and who is not in need of medical priority for rehousing, it is one that impinges on the opportunities available to sick and disabled people to secure health gains through social housing interventions in most local authorities in England. Secondly, in highlighting examples of both good and bad practice, of areas of both effective and problematic collaboration, these findings may encourage and assist housing managers and health professionals to improve the efficiency and effectiveness of their existing partnership and the usefulness of medical input in housing management decisions. Similarly these findings may be useful to other social housing providers who do not have the long experience of local authority housing managers of working with health professionals in the project of housing allocations for health. In particular, the housing association sector has traditionally made less use of health professionals in their housing allocations systems, but as the assessment of health needs has become an increasingly

important element of housing management in the sector (Smith & Mallinson 1997), many of these may need to review and reform their existing systems. Indeed the findings of the national housing association survey whereby a quarter of those housing associations (14/56) operating a medical priority system had increased the involvement of health professionals the last time they reviewed the system, suggests an increasing interest in the alliance concept. Lastly, and more generally, the findings will also give an important insight into one particular healthy alliance already in existence, indeed with a long history. This may be useful to other agencies, in the context of health policy urging their formation, in the process of developing partnerships for health promotion.

4.2 The Role of health professionals in the allocation of council rented housing.

For more than twenty-five years health status has been recognised as a valid criterion for the allocation of council housing and the assignation of medical priority in the housing queues has been a key element of local authority housing management throughout England. Health professionals have worked closely with housing departments in this long-established mechanism of using housing interventions to meet health needs. The responsibility for determining housing need within the legislative framework is formally the responsibility of the housing department. Where legislative definitions of this exist – such as in the case of overcrowding or living conditions unfit for human habitation – they have usually been based on measurable, specific criteria and factors which can be objectively assessed by housing managers with reasonable ease (Spicker 1989). While housing managers have been urged to give priority in their housing queues on health grounds, they have received little guidance, however, on what constitutes health-related housing need. In apportioning medical priority, housing managers have therefore traditionally sought clinical judgements from health professionals (Easterlow & Smith 1997; Parsons 1987; Smith *et al.* 1994).

They have relied on health professionals to make two principal contributions to the process of dispensing medical priority. Firstly, to provide clinical information concerning individual applications; and secondly, to assess and grade completed applications according to their eligibility for priority (Connelly and Roderick 1991; Smith *et al.* 1994). In the former, the medical practitioner acts as an advocate for his or her patient, supplying evidence in support of the application; in the latter, he or she

rations the award of medical priority by prioritising applicants relative to one another. Housing departments have relied on (usually different) health professionals to carry out either or both of these tasks.

The national local authority survey employed here found that in the 1990s nearly all housing departments (114/117) continue to formally consult qualified health professionals in the assignation of medical priority in the housing queues, and that over two-thirds (80/117) do so as part of every medical application decision. The majority (79/114) of these authorities rely mainly on the services of a public health physician, though almost one in five (21/114) consult a general practitioner (GP) most often and a further 11% (12/114) work with an occupational therapist most frequently.

4.3 Providing information

In order that an applicant's eligibility or need for medical priority rehousing can be assessed, case information in support of the application must first be assembled. Traditionally, GPs and, to a lesser extent, hospital doctors, have provided this health information. They have written reports or housing 'lines' to the housing department on behalf of their patient, outlining their health problem and need for rehousing. Over half the surveyed council housing departments always (29/117) or sometimes (39/117) require applicants to arrange for their GP or hospital consultant to support their application in this way.

Despite this traditional reliance on the information supplied by medical professionals, this has not proved to be an unproblematic input. The (limited) literature on the subject points to an apparent dissatisfaction on the part of both GPs and housing departments. Although there is no new information on the views of those doctors writing the reports in the English medical priority project, the case study data and the survey of health advisers include the views of some of those housing managers and other health professionals working for the housing department, who are involved in requesting and assessing these reports.

GPs have been criticised for not providing information that is useful to the housing managers or medical advisers that assess medical priority applications (Connelly & Roderick 1991; Fisk 1984; Reid and Hunt 1986). As long ago as 1969 the Cullingworth report accused GPs of issuing medical housing certificates like

prescriptions in order to get patients out of the surgery (Cullingworth Committee 1969). One medical adviser interviewed during a case study visit felt that as a GP himself, he was in a position to recognise from a medical note whether or not the applicant's own GP genuinely supported the application or indeed simply wanted them out of the surgery. The medical adviser working with the housing department in another authority thought it was just as well that she had done so for some time because it meant that she knew the local GPs and knew which ones would 'write a letter at the drop of a hat' and which ones were 'sincere'.

Fisk (1984) examined 216 medical certificates provided by GPs and hospital consultants to Glasgow district council housing department between 1982 and 1983, and found that as many as twenty did not contain any medical information whatsoever. Even when medical information is provided, doctors often fail to relate these to their patient's current housing circumstances (Fisk 1984; Parsons 1987; Stone 1991). A further quarter of those certificates in Glasgow contained *only* medical information (Fisk 1984). A housing officer responsible for collating health information on behalf of applicants in another of the case study authorities included in the national study, complained that she often has to send applicants back to their GPs to get a second more useful letter. Similarly, a number of the medical advisers surveyed lamented upon the quality of the information they receive from GPs, complaining that it contained only clinical information and arguing that what they need for their assessments are a description of how an applicant's health and housing needs interact rather than simply what the health problems are. The survey of health professionals, on the other hand, found that around one third of those who assess GPs' and hospital consultants' letters considered them very useful, and a further two-fifths find them quite useful.

For their own part, GPs themselves have also expressed dissatisfaction with their role of providing health information for medical priority assessment. They have complained that their input is fruitless (Kohli 1986; Stone 1991), despite being time-consuming (Hodgson 1975). Often they find themselves having to write repeated letters (Parsons 1987). Many therefore question the value of their involvement in the system of medical priority for rehousing (Kohli 1986; Stone 1991). These problems arise largely because of the lack of communication between housing departments and GPs and, as a consequence, the GP's lack of knowledge about the housing system. For example, Kohli (1986), in a study of GPs involved in supplying health information to the local housing department in Edinburgh found that the majority did

not know how many people were on the waiting and transfer lists in the area, nor the number of applications linked to medical needs that were assessed each year. They also overestimated the number of people rehoused on medical grounds. Similarly, GPs may not have the information on an applicant's housing circumstances, usually never having seen the patient in their own home environment, and are, therefore, unable (and sometimes unwilling) to relate this to their health needs (Battersby 1986; Parsons 1987; Stone 1991). This has led some to argue that GPs must learn how the system works and must learn to include the link between their patients' housing and health needs (Kohli 1986; Stone 1991).

Notwithstanding the positive effects such actions may have, the responsibility for improving the usefulness of this type of medical input should not lie entirely with the GP. Housing departments might, for instance, provide guidelines to ensure that GPs know exactly what information is required, should provide feedback on the usefulness of reports written (Kohli 1986) and/or could issue standardised forms for doctors to complete (Connelly & Roderick 1991; Maclennan *et al.* 1983; Reid & Hunt 1986). Indeed, while some of those medical advisers surveyed thought that the GP was not in a position to be able to provide the information required for the medical assessment because they rarely see patients in their own homes (thus arguing that the home visitor's report is more useful), more felt that medical recommendations could be improved if the housing department advised local GPs of the criteria applied in the decision to award priority on health grounds. One medical adviser had himself invested time in ensuring that the information from the GPs writing to him was adequate, in order that he could reach a decision on the basis of it.

In light of these problems, it is interesting to note that many local authorities have developed other means of collecting information about individual applications, either to supplement or replace doctors' notes. Indeed, one in five (23/117) of the housing departments surveyed had reduced their dependence on this source of health information the last time they made changes to the way they operated their medical priority systems. Thus over 40% (49/117) of authorities rarely (n=17) or never (n=32) require applicants to arrange for their GP or hospital doctor to write to the housing department in support of their application.

An increasingly important source of information, on the other hand, and one that has come to replace the GP's note in many authorities, is the self-assessment form (SAF). Twenty-two authorities had introduced SAFs the last time they reviewed their medical

priority systems – ten of these simultaneously reducing their reliance on doctors' housing 'lines'. Thus in all, almost 40% (46/117) of those housing departments surveyed always require medical priority applicants to complete a SAF and a further three sometimes do. And, moreover, 32 (70%) of these departments rarely (n=10) or never (n=22) require extra case information from a GP. In over a quarter (28/117) of all authorities, and almost 60% (28/49) of those that use them, the information supplied in a SAF, therefore provides a sufficient basis on which to assess eligibility for medical priority.

Both types of information source are often, however, also supplemented by information collected during a home visit – usually conducted by a specially trained housing officer. For instance, in 12 of those 29 authorities that always require a GP's note, applicants must also always host a home visit, and in a further 7 they sometimes must. Similarly, in those 46 authorities where all applicants are required to complete a SAF, in twenty of them they are also required to host a home visit and 13 sometimes. (In a further twenty-three authorities applicants are always required to host a home visit, but not to provide a completed SAF or a GP's note).

My point here is that although the input of health professionals, largely through writing health reports, remains significant, the problems associated with this input have led many housing departments to reduce their dependence on the medical profession at this stage in the medical priority process and to develop new means of collecting information relevant to the housing needs assessment. Increasingly the doctor's report has been replaced by user sources of information and the opinions of housing staff.

4.4 Assessing, comparing and prioritising the health needs of medical priority applicants.

Although medical practitioners continue to make a significant input (though perhaps decreasingly so) in providing case information at the early stage of the medical priority process, their most important role – and the most indispensable – according to housing managers, is in assessing applicants' eligibility for medical priority, once all the case material – from whatever source – has been assembled. This is an important role because it represents the only element of the housing management function to be fulfilled by professionals other than housing managers.

The national local authorities survey found that over half (63/114, 55%) of those housing departments that consult health professionals in the implementation of medical priority require a medical adviser to assess case information to determine whether or not priority should be awarded on health grounds. Nearly eight in ten (n=90) expect them to decide how much priority should be given. Table 4.1 (page 81) shows that while housing managers rely mostly on their medical advisers to make these two important decisions, they also ask them to make recommendations, on the basis of the case information, on the most suitable type and location of accommodation and how quickly rehousing should take place.

This role of the health professional in the assessment of medical need has developed from the traditional involvement of the old Medical Officer of Health (MoH). The Medical Officer wielded great power in the allocation of local authority housing, particularly in the inter-war years, in ensuring that existing or prospective council tenants received the housing they needed in order to control the spread of infectious diseases such as tuberculosis (Bickler 1988). In the 1973 NHS reorganisation Act the traditional responsibilities of the former Medical Officers of Health, in providing advice to local authorities, were transferred to the Community Physician – later to become known as the public health physician (Parsons 1987).

Reflecting this point, the majority of medical advisers surveyed in the national medical priority study are public health physicians: one third (30/89) of those surveyed describe themselves as senior clinical medical officers; a further third are either directors of public health (14) or consultants in public health medicine (14); and the remainder are consultants in communicable diseases (6) or senior registrars in public health medicine (5). The respondents include just five occupational therapists and four general practitioners (six gave some other title, and nine gave no job description).

4.4.1 Models of collaboration

Health professionals, particularly public health physicians, therefore play an important role in the operation of medical priority in most authorities and, in this way, may exert significant influence over the allocation and use of the council housing stock. There is evidence, however, that many local authorities have reduced the involvement and influence of health professionals in medical priority decisions, developing alternative models of collaboration. The identification and prioritisation of medically-related

housing needs is considered here to be primarily a *housing* management function and housing professionals take the lead in making these decisions. Indeed in 45 (38%) of the authorities surveyed, it is housing managers who make the final decision concerning the award of medical priority. Thus the contribution of health professionals in the assessment of health need and apportionment of medical priority varies from authority to authority, according to not only whether doctors are called upon to provide the health information required to make the needs assessment, but according to how the housing department involves health professionals in the management of its medical priority system.

Three models of management showing the different levels of involvement of the health professional in the assessment of health need have already been identified (Smith *et al.* 1991):

i) The ***farmed-out, health professional-led*** model where a health adviser is always consulted by housing managers and always makes the final decision concerning the award of medical priority. 46% (52/114) of the surveyed authorities practice this model of management. In these authorities, housing managers simply implement these decisions or recommendations.
ii) The ***in-house, housing manager-led*** model where health advisers are not always consulted and where the final decision on medical priority rests with the housing manager. This model is practiced by a quarter (26/114) of housing departments.
iii) The ***intermediate*** model where *either* health professionals are always consulted but are not required to make the final decision (which is left to housing managers or decided in committee), *or* health professionals are not always consulted, but when they are, they take on full discretionary powers concerning medical priority awards. 28 of the surveyed authorities were found to practice the first type of intermediate model, but just 8 the second. Thus, in all, 36 (32%) practice this model.

In these latter two systems only selective use is made of health professionals and housing managers retain most responsibility for assessing health needs and awarding medical priority. Thus in over half the authorities surveyed, the input of health professionals is limited[1].

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[1] Indeed, among these authorities, medical input can involve the provision of case information only. The survey of health professionals, however, includes only those medical advisers involved in assessing medical priority applications.

Together, the surveys of medical advisers and local authority housing managers and the case study findings give a detailed insight into this particular involvement of health professionals in council housing management. Moreover, all three of the identified models of management and of collaboration are represented in each source of information. Overall, half (45/89, 51%) the sample of surveyed health advisers work in a 'farmed-out' system where the whole medical priority package is delegated to them, and where housing managers simply implement their decisions or recommendations. The remainder are involved in systems where more limited use is made of their expertise: 28 (31%) work in intermediate systems and a further 16 (18%) in in-house systems. Farmed-out and in-house models of management are each practised in four of the case study authorities[1] ; the remaining authority employs an intermediate system.

Although the range of tasks carried out by medical advisers in their role as case assessors has already been identified, Table 4.1 shows that these vary according to the model of medical priority operating. Not only do those health professionals working in farmed-out systems play a greater role overall, but they are most likely to make decisions concerning the fact and extent of priority, and do so in the vast majority of these authorities. In in-house and intermediate departments, making recommendations is more important and health professionals tend to fulfil more of an advisory role, reflecting the greater involvement of housing managers in the final decision concerning the award of priority.

What is more, not only do farmed-out authorities delegate most responsibility to health professionals in assessing and prioritising cases, but they also make more use of medical input more generally. The model of management employed also has implications for the reliance on (other) health professionals for the provision of health information as described earlier. For example, housing departments with farmed-out and intermediate systems are 12% more likely to require all applicants with health needs to arrange for their GP or hospital doctor to write to the housing department. Farmed-out authorities are also, however, more likely to require all applicants to complete self-assessment forms: 26/52, 50% compared with 7/26, 27% of in-house authorities and 13/36, 36% of intermediate authorities. What this means is that the use of SAFs does not, in the majority of cases, replace all input of medical opinion. In-

[1] In one of these in-house authorities (Southplace), the only contribution of health professionals is, however, in the provision of health information to the housing department.

Table 4.1 The role of the medical adviser in three different medical rehousing management models

Role of health adviser	All authorities %/114	Management Model: Farmed-out %/52	In-house %/26	Inter-mediate %/36
Determines whether to give medical priority*	55	71	31	50
Determines how much priority to award*	79	86	58	83
Recommends the type of home to be allocated	77	81	62	83
Recommends the location of the dwelling	19	21	8	25
Recommends how soon rehousing should occur	33	33	19	44
Provides information to housing managers	16	12	31	11

Source: Local authorities survey
* Differences between models on these variations are significant at $p<0.05$, using the Kramer's V statistical test. References to statistical significance throughout the rest of the thesis also relate to this test.

house systems are more likely to depend on home visitors to provide the necessary case information. Nearly two-thirds (16/26) of these require all applicants to be visited at home by specially trained officers, compared with 37% (19/52) of farmed-out systems and 47% (17/36) of intermediate systems. In-house systems are more likely to sometimes require a GP's note, but this is usually simply to supplement the home visitor's report. It follows, therefore, that for 25/45 (56%) of medical advisers working in farmed-out and 18/28 (64%) of those in intermediate systems, case assessment involves considering letters or reports from the GP and/or hospital doctors treating the applicant, compared with only a quarter of those servicing in-house departments. Similarly, half (24/45, 53%) of medical advisers servicing farmed-out authorities are involved in the assessment of SAFs, compared with a third (9/28) and less than one in five (3/16) of those working in intermediate and in-house departments respectively.

It is thus hardly surprising that, while most medical advisers report that they liase with other health professionals concerning the award of medical priority – just 7 (8%) say they do not – those working in farmed-out and intermediate systems are much more likely to liase with a range of medically-qualified professionals. Table 4.2 shows that while it is the applicant's own GP whom all medical advisers liase most widely with, irrespective of the system of management, this is especially the case in in-house authorities.

Table 4.2 Medical Advisers' liaison with other health professionals when awarding medical priority.

		Management Model		
Type of health professional	All advisers %/89	Farmed-out %/45	In-house %/16	Inter-mediate %/28
Applicant's own GP	89	93	81	86
Applicant's own consultant or specialist	80	87	56	82
Applicant's own psychiatrist (where applicable)	71	80	44	71
Nurse/health visitor	65	73	31	71
Occupational therapist	47	49	25	57
(Other) hospital doctor	29	27	31	32
(Other) public health physician	23	29	19	14
Other non-clinical health adviser	20	24	0	25
GP working for housing department	11	11	19	7
None	8	4	19	7

Source: Medical advisers' survey

Thus while the majority of advisers working in farmed-out and intermediate systems also claim to work with nurses/health visitors, the applicant's own hospital consultant or specialist, and their own psychiatrist, those in in-house systems are much less likely to do so. Input from a range of health professionals, other than GPs, seems therefore to be limited in those authorities who also make least use of a medical adviser in assessing priority claims, and in-house authorities thus make least use of the 'healthy alliance' concept overall, minimising the involvement of the medical profession in the allocation of housing.

4.4.2 Housing managers and health professionals: an appropriate alliance?

It is the role of local authority medical adviser that the existing literature highlights as being the most problematic involvement of the health professional in medical priority rehousing. While it is not suggested that all involvement in issues of housing and health should end, calls have been made for a re-assessment of the appropriateness and future of this particular role (Bickler 1988; Campbell *et al.* 1994; Connelly & Roderick 1991; Lowry 1991; Muir Gray 1990; Parsons 1987; Roderick *et al.* 1991). An important point here, however, is that these views relate largely to public health physicians in single authorities, working in what are termed here, farmed-out systems. Little is known, on the other hand, of the opinions of other health professionals or those working in alternative systems, nor of housing managers hitherto relying on their involvement in medical priority rehousing.

Health professionals have expressed concern in the literature over the amount of time they spend on assessing applications for medical priority (Muir Gray 1978; 1990; Parsons 1987) and, given a national shortage of public health physicians (Roderick *et al.* 1991; Salter 1993), medical priority, it is claimed, is a drain on health service resources, particularly the public health department. In a survey of directors of public health in all district health authorities in England and health boards in Wales, Scotland and Northern Ireland, almost three-quarters reported an involvement of their department in medical priority (Roderick *et al.* 1991), and medical advisers spend as much as one day per week assessing medical priority applications it has been suggested (Hodgson 1975). Following the separation of the purchaser-provider function in the NHS, and the redefinition of the role of public health physicians as *purchasers* of health care, it has been argued, moreover, that they might no longer

have the time or energy – or inclination – to invest in continuing their collaborative work with other agencies outwith the health service (Whitty & Jones 1992; Watkins 1994).

It was in the context of resource shortages in the public health profession that the Acheson Report (Department of Health 1988) advised almost ten years ago that public health physicians should avoid roles that non-medical personnel could fulfil. Medical assessments for housing departments were identified as one such role.

Furthermore, it has been suggested that the rationing of a health intervention – in this case a 'healthy' home – is not an appropriate role for the medical profession in general and the public health profession in particular, especially since medical priority might, in any case, be ineffective in securing a home for even those most in need (Cole & Farries 1986; Connelly & Roderick 1991; Gardner & Troop 1981; Howells 1984; Lowry 1991; Parsons 1987; Roderick *et al.* 1991). Parsons (1987) argues that 'prioritising cases is fundamentally contrary to medical training where the doctor acts as advocate for the sick' (p.440). Public health professionals should, rather, be involved in campaigning for healthy housing for all (Lowry 1991; Muir Gray 1990).

An important point here then is that not only are public health physicians more closely linked with the role of medical assessor than any other health professional in numerical terms, but that they are also more likely to be afforded considerable power and autonomy in the medical assessment process. Over half (38/69, 55%) of those public health professionals surveyed work in housing departments operating a farmed-out management model, compared with a third (5/15, 33%) of other health advisers. Just 9 (13%) work in an in-house system and 22 (32%) service intermediate authorities. Thus these expressions of dissatisfaction, particularly if they were to be translated into a withdrawal of involvement in medical priority, may be of particular significance to the majority of local authorities in England.

The national data set available here allow for an investigation of the criticisms voiced in the literature and enable a consideration of the relevance and appropriateness of health professionals to housing management. On the whole, the findings do not support the criticisms for the following reasons.

First, the health advisers' survey suggests that medical priority rehousing does not absorb a disproportionate amount of health professional's time. Nearly a quarter of the

advisers surveyed spend only one hour per week on case assessments and just 11% spend ten hours or more. The majority spend less than three hours per week and this is true of all models. Public health physicians do not, moreover, devote more time to case assessment than other health professionals servicing the same management model.

Moreover, despite the literature pointing to medical advisers' frustration at the ineffectiveness of their medical priority awards in securing suitable housing and health gains, three-quarters (67/89) of medical advisers surveyed in the national study regard medical priority as a productive means of using housing solutions to meet health needs; just 5 think it is not an effective or efficient method of promoting health. According to the health professionals surveyed here, medical priority *is* an effective health intervention.

Reflecting these points, four out of every ten (38/89) health advisers feel that their involvement in medical priority rehousing constitutes both an effective and efficient use of their time, and in all 70% (62/89) agree that this is true, at least to some extent. Ironically, those very health advisers who spend most time in case assessment – those working in farmed-out and intermediate systems – are more likely to consider their input to be effective and efficient than those employed in in-house systems (differences between the models in this view are statistically significant at $p<0.05$). Just 6/16 (38%) of those latter respondents say this, compared with almost nine out of ten (65/73) of all others. Furthermore, public health physicians are especially likely to think both that the assignation of medical priority in the housing queues is an effective health intervention (55/69, 80% compared with 8/15, 53% of other health professionals) and that the demands of their involvement in the system constitute an effective and efficient use of their time (51/69, 74% compared with 8/15, 53% of non-public health professionals).

The role of medical adviser is also one that health professionals and the housing managers they work with, think is relevant and appropriate to housing management decisions. Fully 63/89 (71%) of the health advisers surveyed, think it appropriate for someone in their position to be carrying out medical priority assessments. This view is most widespread among advisers operating farmed-out and intermediate systems (31/45, 69% and 24/28, 86% respectively compared with 8/16, 50%). It is however less so among public health physicians (44/69, 64% of public health physicians think this, compared with 12/15, 80% of other advisers, $p<0.05$), though interestingly one

adviser thinks that, contrary to the prevailing view, it is exactly her public health training that makes her suitable for the job. She argues that she is a 'trained decision-maker' and, as a result, in an ideal position to make judgements about whether particular cases merit priority.

Housing managers agree. Fully, 79% (90/114) of housing managers surveyed say that the medical adviser to their department provides an assessment of housing need that could not otherwise be made – one that could not be made by themselves. Moreover, this view is held by the majority of housing managers operating all management models. This is an interesting point given the fact that in in-house systems, housing managers already make the decision concerning the award of priority in the majority, if not all, of cases – cases that would be left to the opinion of health professionals in farmed-out and (some) intermediate systems. It reflects the fact that even in in-house authorities where the assessment of health-related housing need – like any other housing need – is considered to be a housing management function, housing managers still depend on the advice of health professionals, even if only in the minority of cases when they themselves are unsure.

Despite these promising findings, however, the data also suggest that medical advisers believe that their role as case assessors could be fulfilled adequately by specially-trained local authority housing professionals. Over one-third (31/89) of health advisers think that, given adequate guidelines and training, housing managers could draw the same line as they do between those who should and should not receive medical priority most of the time. Nearly three-quarters (64/89, 72%) believe this would sometimes be possible. Only 14 (16%) advisers think they would be unable to do so. This difference in opinion between housing managers and health professionals means that in over three-quarters (50/64) of the authorities where medical advisers think that housing officers could at least sometimes take over the assessment of medical cases, housing managers argue that the medical adviser provides an assessment of need that they themselves cannot make. Over half (49/89, 56%) of the surveyed medical advisers also advocate an increased use of specially trained housing officers. Interestingly, advisers servicing farmed-out housing authorities, are not, on the whole, more likely to think that housing officers could take over the decision-making of most cases (like they do in in-house systems), though public health physicians here are more likely to say that they could. 39% (27/69) of public health physicians say that

housing officers could come to the same decision most of the time, compared with just 13% (2/15) of other advisers.

What all this suggests is that health professionals might, afterall, be reassessing their role in medical priority rehousing. A number of important points must, however, be highlighted.

Firstly, the in-house model of housing management represents the most limited involvement of medical advisers in case assessment and priority decisions, and thus the model into which the persuasive arguments for reducing or even removing this input are built. Since health professionals working in these systems appear least satisfied with their role, reducing the input of those health professionals involved in the other systems might not be an effective move. Housing departments may have developed in-house arrangements in response to the problems associated with the use of health professionals and/or reflecting the belief that medical priority is a housing issue, but the medical advisers and housing managers surveyed working in farmed-out and intermediate systems, i.e. the majority of authorities, continue to see it as a medical issue and one that benefits from joint collaboration.

Furthermore, while public health physicians – those who are most likely to fulfil the role of medical adviser – are particularly likely to think that increased use should be made of specially trained housing officers, they are reluctant to see this come at their own expense. Crucially, while 20 public health physicians (29%) feel that housing departments should reduce their dependence on public health professionals, over two-thirds disagree, saying that they should continue to use them in their existing roles (39/69, 57%) or should increase their role (8/69, 12%). Moreover, this is true of public health physicians working in all management models.

Secondly, what appears to underpin any dissatisfaction among health professionals of their role as medical adviser, is not the principle of using local authority housing interventions to meet health needs, nor their own involvement in it, but rather the frustration of trying to operationalise the idea of medical rehousing in the context of housing shortages. The comments made by three medical advisers surveyed reflect this point:

> *The demand for rehousing so outstrips supply that my medical priority grading looks to be relatively meaningless.....*
>
> *Assigning medical priorities is a waste of time when the housing*

stock is so low as to be virtually non-existent.....

The time of the present system has probably run out locally due to demand for medical priority outstripping any hope of supply

The point is similarly reflected in the rather mixed feelings expressed by medical advisers towards the issue of whether the system of medical priority for rehousing could be improved in any way. While 45% (40/89) do not believe it can be improved because of the extent to which demand from people with health needs outstrips the supply of suitable accommodation, a similar proportion (43/89, 48%) feel it could be improved with the injection of extra resources.

Without adequate availability of suitable accommodation, the medical priority system is an archaic relic which can scarcely have relevance, yet it is, and should be relevant.

I don't feel that the present system.... needs any alteration - it has stood the test of time. The housing provision is the one that should be improved to cut down waiting lists.

Thirdly, not only do medical advisers think they play a legitimate role in the dispensation of medical priority for rehousing, but, as Table 4.3 shows, they do not wish to see the weight of their decisions reduced. Only three medical advisers surveyed (3%) think that their decision of whether to award medical priority should carry less weight; 65 (73%) say it carries the right amount of weight and 11 (12%) say it should carry more. Similarly, while no advisers think their decision concerning how much priority to award is too influential, over half (63/89, 58%) think it is about right and 17% (n=15) feel it should be more so. Those advisers working in in-house systems are slightly more likely to think that their decisions should carry more weight. Over three-quarters of public health physicians also feel that the influence of their decisions concerning the fact and extent of priority is about right.

This all suggests that not only do housing managers think that the involvement of health professionals in housing management in this way is an important one in ensuring that medical priority is allocated fairly, but, on balance, that health professionals agree. Neither group seem to wish to see this input withdrawn altogether.

Table 4.3: Medical advisers' views on the weight their recommendations carry in the housing system.

		Model of Management		
	All advisers	Farmed-out	In-house	Inter-mediate
Recommendation	%/89	%/45	%/16	%/28
Award of mp				
carries correct weight	73	82	44	75
needs more weight	12	9	25	11
needs less weight	3	0	6	7
Award of top mp				
carries correct weight	71	37	50	79
needs more weight	17	18	25	11
needs less weight	0	0	0	0
Type of home				
carries correct weight	58	67	38	57
needs more weight	26	27	38	18
needs less weight	0	0	0	0
Location				
carries correct weight	46	44	44	50
needs more weight	12	11	6	18
needs less weight	1	2	0	0

Source: Medical advisers survey.
mp = medical priority

4.4.3 Discretion, accountability and the relationship between housing managers and health professionals in medical needs assessment.

Although medical advisers, particularly those servicing farmed-out and intermediate systems, report they liase widely with other health professionals when making medical assessments, collaboration with housing managers is ironically much less common. The evidence here suggests that there is a marked division of responsibility between housing and health matters in the management of medical priority. Over 70% (63/89) complete their medical assessments independently of housing managers, and in the majority of cases (37/63, 59%) the results are simply handed onto housing officers without any formal pattern of collaboration. As might be expected, this pattern is most marked in farmed-out and intermediate systems where 34/45 (76%) and 24/28 (87%)

work independently (compared with 5/16 (31%) operating in-house arrangements). By definition, farmed-out systems offer greater autonomy to the medical adviser, and decisions seem to be accepted without question. Public health physicians are also more likely to carry out their assessments without any collaboration, even controlling for model of management. Thus, in all, 78% (54/69) of public health professionals complete their assessments independently and this includes 79% (30/38) in farmed-out systems, 91% (20/22) in intermediate systems and 44% (4/9) in in-house authorities. In 64 authorities, moreover, medical advisers' decisions concerning the award of medical priority are considered to be binding.

This has led some to question the involvement of health professionals in housing management decisions on the grounds of its unaccountability (Bickler 1988; Easterlow & Smith 1997). Unlike the old Medical Officers of Health, modern day medical advisers are not local authority employees but rather, health authority employees. As such medical housing assessments, when made by health professionals, represent the only part of the housing management function to lie out of the control of the local authority and this opens up a potentially large gap of accountability. Smith and Mallinson (1996, p. 346) argue that 'the discretionary judgements required to regulate demand are displaced from an arena in which they are visible, accountable and potentially rational, to one in which they are invisible, unconstrained and less easy to justify'. Thus it has been suggested that this area of housing management contains a great deal more discretion and unaccountability than any other (Bickler 1988). Even worse, it has been argued that housing departments positively take advantage of this lack of accountability of their medical advisers by playing on the deference of the public to the medical profession, by using their medical adviser to legitimate difficult decisions and deflect criticism from the housing department: 'The experience of community physicians throughout the country seems to suggest that the cuts in the housing budget..... are being cloaked by the mysticism of the white coat and stethoscope....' (Parsons 1987, p. 440).

This is a charge that housing managers themselves deny. Less than a third (34/114) of those housing managers interviewed identified an increased confidence among applicants in the housing allocations procedure as one of the most important advantages of involving health professionals in the role of needs assessment. Similarly, just one in five (23/114) thought that one of the most important benefits was the spreading of responsibility for allocating a limited housing stock of uneven quality. Moreover, housing managers in those authorities where demand for medical priority

outstrips the supply of suitable housing are not more likely to think this. Housing managers maintain that health professionals are involved in the management of medical priority rehousing *only* because they provide an assessment of need that could not otherwise be made.

But this deference of housing managers to health professionals means that not only are decisions concerning the allocation of medical priority reached with little collaboration, but that they are made completely at the discretion of the medical adviser, often with little understanding of how or why. Indeed the evidence here suggests that in some authorities medical priority rehousing is, to all intents and purposes, a housing service managed by the medical adviser and not the housing department.

Only half (47/89) of the medical advisers surveyed had received written or verbal guidelines from the housing department on the medical needs assessment procedure. Interestingly, although 'in-house' advisers more commonly liase with housing staff when carrying out their assessments, these advisers are least likely to receive guidelines on how to assess housing-relevant health needs. Just a quarter (4/16) of in-house advisers receive guidelines, compared with 62% (28/45) of those working in farmed-out systems, and 54% (15/28) of those in intermediate systems. Thus in making their decisions concerning the award of medical priority, medical advisers may not be working to housing department policy (if any exists) regarding who is and who isn't eligible for medical priority. Table 4.4 shows for instance that medical advisers are not always aware of housing department rules on who is eligible for medical priority.

In fact, it may not be the housing department that determines the rules of eligibility, but rather the medical adviser. Over a third (33/89, 37%) of the medical advisers surveyed said that they themselves or their predecessors had been involved in developing or revising the housing department's medical priority guidelines. In two of the farmed-out case study authorities (Seaton and Hambley) the advisers work to guidelines, but guidelines they have developed themselves (though the survey of medical advisers does not suggest that health professionals in farmed-out systems are more likely to be involved in preparing these). Moreover, in all five farmed-out and intermediate authorities, housing officers work towards submitting applications that will meet with the approval of the medical adviser or wording them in a way that they think will meet with his or her approval (although they were not always clear about

which cases would secure priority and which would not). In Hambley, housing officers are issued with the doctor's guidelines and are required to attend seminars

Table 4.4 Level of agreement between housing managers and medical advisers in the same housing department concerning eligibility for medical priority.

Factors associated with eligibility	Housing manager & medical adviser agree		Housing manager & medical adviser disagree	
	n	%/89	n	%/89
Housing conditions may be causing illness	54	61	22	25
Poor health affects use of dwelling	81	91	1	1
Dwelling may be making health worse	79	89	0	0
Rehousing would improve health	68	76	5	6
Rehousing would improve quality of life	51	57	21	24
Suffers from list of acceptable clinical conditions	26	29	35	39
Risk of non-accidental injury	29	33	28	31
Rehousing would improve access to informal care	48	54	24	27
Rehousing would mean carer being nearer to ill person	38	43	32	36

Source: Local authorities survey matched with medical advisers survey.
Note: Row totals do not equal n=89 and 100% because where housing managers and/or health advisers could not answer, these were excluded.

conducted by *him* to make sure they are aware of his views on eligibility. It is clear that in the two farmed-out systems and the intermediate authority (Albury), the medical advisers wield great power and influence (the adviser in Hambley is described as the

linch pin of the whole system), are afforded a great deal of discretion and are not formally accountable.

A further danger of farmed-out systems is that, in the process of leaving the final decision-making to the health adviser, housing managers are encouraged to believe that they themselves do not influence medical priority outcomes, when the evidence included in the following two chapters suggests they do. This means that when housing staff do make judgements – often on an informal basis – these are not accountable either. An important point here, however, is that discretion and unaccountability are not problems associated only with those systems that involve a health professional in the role of case assessor. The issue, as Smith and Hill (1992) argue, is one of bringing the decision-makers to account rather than one of who makes the decision. Thus one farmed-out department among the case study authorities provides an example of good practice on these grounds. Although the health adviser takes full responsibility for the award of medical priority, she has frequent contact with members of the housing staff and this allows for particular cases to be discussed. It also gives officers the confidence to question her decisions.

The lack of information supply from the housing department to its medical adviser not only undermines the accountability of this alliance, however, but may compromise its effectiveness. The discrete decisions medical advisers make may not even be based on a sound information base and may not, in the end, be useful to housing managers who must implement them.

Most health advisers have only a meagre knowledge of the characteristics of the local housing stock and of the housing allocations systems they are part of. Table 4.5 shows, for example, that less than one in four advisers surveyed know how much socially rented housing (council or housing association) is available locally, and only one in three know the length of local waiting lists. Levels of knowledge are least among advisers servicing in-house systems. This might reflect the fact that health professionals are involved in assessing only limited numbers of cases, and even then the final decision rests with a housing manager who does have this knowledge. Although knowledge of the housing system is greater among those advisers working in farmed-out (and intermediate) departments, it is nonetheless worrying that levels are still so low. Medical advisers may be assigning priority indiscriminately to applicants who have little or no chance of being rehoused because of a shortage of suitable housing in the authority. It is hardly surprising in this light that only half of those

surveyed (44/89) think that medical priority rehousing represents an effective means of matching applicants with health needs to suitable available housing. The problem of inadequate information supply may be compounded further by the fact that few health advisers are provided with feedback on their decisions and few therefore know how many applicants awarded priority are rehoused and how soon.

Table 4.5 Medical advisers' knowledge of the local housing system

Type of Information	% who routinely receive information			
	All /89	Farmed-Out /45	In-House /16	Inter-mediate /28
Amount of council housing owned by local authority	22	27	6	25
Housing Association lets available to local authority	12	16	0	14
Amount of ground floor accommodation available*	23	31	0	21
Amount of sheltered housing*	29	38	0	32
Amount of dwellings at mobility standard	21	24	6	25
Proportion of stock damp or unfit	10	16	0	7
Length of waiting lists*	36	49	13	29
Average waiting time for those with top medical priority*	28	36	0	32

Source: Medical advisers survey
* Differences by management model in these responses are statistically significant at $p<0.05$.

While general knowledge about the availability of suitable housing among health advisers is limited, many are routinely supplied with case-specific information on the current housing circumstances of the applications they process (Table 4.6). Nine out of ten (80/89) receive information from the housing department on the type of

dwelling (including floor level) currently occupied; four in five have details of locations. But only three-quarters (68/89) know what aids and adaptations are currently in use; just two-thirds (60/89) are kept informed on dwelling condition and state of repair; and a little under half know how long each applicant has been waiting to move. Thus although case-specific housing information is more widely available to health advisers than is the more general information about the local housing stock, even this is limited. And again, the poorest information base is found among advisers operating in-house models.

Table 4.6 Medical advisers' knowledge of the current housing circumstances of applicants

Type of information	% who routinely receive information			
	All /89	Farmed-Out /45	In-House /16	Inter-mediate /28
Time on waiting list	45	40	31	61
Type of current dwelling lived in	90	96	63	96
Condition of present dwelling*	67	69	38	82
Location of present dwelling*	83	89	50	93
Floor level of present dwelling*	90	93	69	96
Aids and adaptations in present dwelling	76	80	63	79

Source: Medical advisers survey
*Differences by management model in these responses are statistically significant at $p<0.05$

The irony of this slim information/ knowledge base is that most advisers say they attach great weight to general and case-specific housing information when making their health assessment. Over half (46/89) the medical advisers surveyed say that current housing characteristics have a bearing on outcomes 'to a large extent in many cases' or 'to a great extent most of the time'. This view is less widespread among those servicing in-house systems (6/16, 38%) than others (35/45, 56% in farmed out

systems and 15/28, 54% of those in intermediate systems). However, fully 83/89 (93%) advisers, irrespective of their management model, say that the effect of dwelling conditions on occupants health is important in their decision to assign medical priority and nearly half (43/89, 48%) say the location of the current dwelling is also important. Four out of five respondents (71/89) – the same proportion in all management systems – cite adverse housing conditions as influential in their decision to award the highest levels of medical priority available. Nearly half (44/89) say they take into account the likelihood of a suitable dwelling becoming available when assigning medical priority. Ironically, those who attach most importance to this tend to know least about the housing system.

Crucially then, it seems that although medical advisers claim to be taking housing issues into account when carrying out their medical needs assessments, the information and knowledge base from which they are expected to do this is generally quite weak.

4.5 Conclusion

The collaboration of housing managers and health professionals is one example of a 'healthy alliance' spanning more than 50 years. It is one that, while taking a number of different forms, involves health professional involvement in determining who, among medical priority applicants, is in need of rehousing. It is a particular example of joint-working that both agencies involved – housing managers and health professionals – find highly satisfactory and appropriate and one which is effective in securing health gains through housing interventions. As such it represents an established, relatively successful, example of a healthy alliance, and one that other housing providers as well as other agencies whose activities impinge on the population's health can learn from. In today's health policy context it may therefore be an alliance worth preserving.

It is one, moreover, that, from the point of view of health professionals in particular, works best when their involvement in medical priority is maximised. Medical advisers working in farmed-out and intermediate authorities, for instance, are more satisfied with their particular role and with the system of medical priority rehousing in general, than are those who service in-house models of management.

The chapter has, however, highlighted a number of problems associated with the operation of this alliance in all its forms and which, it seems likely, might be true of a range of other health-promoting partnerships. Some of these problems relate to the resource shortages currently experienced in the local authority housing sector. Others, however, relate to the limited collaboration between housing managers and health professionals, and are therefore problems that can be overcome. The findings here suggest that the alliance between housing managers and health professionals is not as well developed as the long history of medical rehousing might imply.

The limited information supply between these two agencies restricts the usefulness of the involvement of the health professional in medical priority. Limited collaboration also crucially leads to the unaccountability of the medical needs assessment process when assessments are carried out by a medical adviser, particularly in farmed-out systems. This is important because it means that it may not be open to redress and the equity and fairness of the procedure may also be open to question in most authorities in England.

An important point, however, is that it is not only the partnership between housing managers and health professionals in the management of medical priority that undermines the equity of the system. Housing managers and housing officers, at a number of points in the application process, make discretionary judgements and decisions that unequally affect the opportunities of different groups and individuals to secure medical priority rehousing, as Chapters Five and Six will now go on to show.

5

ACCESS TO MEDICAL PRIORITY REHOUSING

5.1 Introduction

Chapter Three described how social services in the British welfare system have traditionally distributed their resources on the basis of need. In a situation where levels of need in the population exceed available resources, clearly not all those needs can be met adequately or at all. In the field of housing, what this means is that some people in housing need will have a long wait to be rehoused, some may be accommodated in housing unsuitable for their needs, while others may not be housed at all.

I am concerned here, in a context where demand for medical priority rehousing exceeds the supply of suitable accommodation among a majority of local housing authorities and housing associations, with the strategies employed by housing managers to ration this resource, and with what this means for the opportunities available to people with health needs in the social housing system.

Although the attempt by housing managers to regulate demand at the point of allocation has been well-documented in the existing housing literature, the existence and importance of what were described in Chapter Three as strategies of primary rationing, has largely been ignored. This chapter will review in detail the evidence, introduced by Smith and Mallinson (1996), suggesting that, just like other service providers, social housing managers do in fact implement a range of primary rationing strategies in order to regulate, not just the allocation of resources, but also the demand for medical priority rehousing. This appears to be true even of those housing authorities and associations who say they have adequate resources to match the demand for medical priority rehousing. Chapter Six will then go on to explore strategies of secondary rationing in the social housing system that might impinge on

the housing opportunities for those individuals and households who are awarded medical priority in the housing queues.

The range of data sources available from the national medical priority study provides the opportunity to explore and describe the existence of a range of rationing methods: those that are acknowledged, intentional and formal, as well as those that go unrecognised, are inadvertent, informal and unanticipated. The surveys of housing managers, for instance, are well placed to describe formal procedures – what housing managers say they do – while the detailed case study material, together with documentary information and application forms, is particularly suited to documenting what managers actually do to contain demand for medical priority rehousing. I therefore draw particularly on my own analysis of the case study material, linking this in-depth qualitative data with key points from a local analysis of the national surveys.

The outcome of these rationing strategies is not just to limit access to the best quality housing within the housing stock for some groups of applicant, but also to prevent some people from even queuing for a home on health grounds. The chapter aims to show how these strategies differentially affect those with health needs and how different groups experience and deal with them, in order to determine how they unequally impinge on their housing opportunities. The aim is to show how access to medical priority rehousing may not be equal for all those with health needs. An important element of this may be geographical differences in the existence and extent of primary rationing, so that local authority of residence – where people live – affects their opportunities to mobilise a medical priority system.

The primary rationing of medical priority for rehousing involves restricting access to the medical priority system and limiting the award of medical priority. I will begin therefore with a discussion of those strategies that affect the chances of households applying for medical priority and reaching the point of needs assessment, before turning my attention to the outcomes associated with the formal process of apportioning medical priority. Throughout I will be concerned with the way that the attempt to ration demand may interfere with the aim of allocating according to (health) need and with highlighting the potential for inequitable outcomes to occur both within and between local areas.

5.2 Rules of eligibility

Formal rules of eligibility for welfare assistance are used widely throughout the British social services, including social housing, as an overt means of regulating demand (Foster 1983; Parker 1975). Such rules ration welfare by explicitly excluding all but a strictly delineated group from benefit. Although in principle these rules should work to discriminate between those who are more needy and those who are less needy, in practice need is only one factor determining who does and who does not secure assistance.

For instance, the surveys of local authorities and housing associations found that a range of people are excluded from the social housing system. Those most commonly excluded from joining the housing waiting lists are people deemed to be adequately housed (by 22% of local authorities and 25% of housing associations), pre-retirement owner occupiers (by 33% of local authorities and 14% of housing associations) and higher income groups (by 11% of local authorities and 28% of housing associations). Such groups are deemed not to be in need of a move or not in need of welfare assistance. These groups, together with the 'intentionally' homeless (excluded by 15% of local authorities) and those with no local connection (excluded by 68% of local authorities and 4% of housing associations) are similarly often considered 'undeserving' of assistance.

What is also important to highlight here is the varying extent to which housing providers rely on this means of rationing welfare. Some authorities and housing associations exclude several groups, while others exclude none, perhaps reflecting the different levels of pressure they are under generally as well as from these particular groups. This might have important consequences for access to social housing generally and medical priority in particular.

Despite the formality of such official rules of eligibility, flexibility often exists in dealing with those excluded (Niner 1975). In particular, medical needs can usually outweigh ineligibility for rehousing on other grounds. In the local authority sector, those with no local connection, under-18s and tenants in arrears continue to be excluded (in 43%, 15% and 15% of local authorities respectively), while many housing associations continue to exclude those with incomes over a threshold, people who are adequately housed, the under 18s and young owner occupiers are excluded by a number of associations even if they have health needs (by 22%, 20%, 13% and

12% respectively). All other groups, however, will usually be admitted to the waiting lists. This has led Smith *et al.* (1991, p.8) to conclude that 'medical priority is.... almost universally available and, in that sense, ... is the element of housing management that most clearly retains elements of the "welfare ideal" '. In other words, at least in principle, sick and disabled people are not, on the whole, excluded from consideration for rehousing on grounds other than their health needs.

It is worth making a number of important points here however. Firstly, medical priority is, at least formally, more widely available in some areas than others. Some housing authorities and associations rely more on this means of regulating demand from people with health needs, excluding more groups, than do others.

Secondly, although these debarring rules might formally be overridden, potential applicants might not always be aware of this. When the rules are published in information leaflets or on application forms, they are not usually accompanied by an explanation of how they do not necessarily apply to those with health needs.

Thirdly, as we shall now see, formal eligibility rules do not represent the only strategy of rationing medical priority on grounds other than need.

5.3 Expressing medical need

Bradshaw (1972) distinguishes between 'felt' need and 'expressed' need. If a person (subjectively) perceives themself to be in need, then they experience felt need. Expressed need can be equated with demand. Although people might express a need without actually experiencing it, expressed need largely represents felt need turned into action. The British social services, in the allocation of their resources, have traditionally relied on people expressing need in this way. They have thus seen their task as differentiating between those individuals who express a need and allocating resources to those *they* consider to be in need. Thus resources are allocated according to a professional rather than a lay definition of need. Bradshaw terms this 'normative' need.

But individuals can also experience need without expressing it. In employing demand for a service as a proxy for need for that service, social services have traditionally exploited the discrepancy between 'felt' and 'expressed' need as a means of rationing.

In other words, as Parker (1975) argues, one way in which they have controlled need is by assuming that some of it does not exist. From the perspective of welfare providers, it is easier to balance apparent, or expressed, need and available resources, than to probe deeper and expose a more widespread hidden need.

One concern of this chapter is to explore why people might not express health-related housing needs, despite experiencing them. Another is to illustrate how social housing providers, whether intentionally or otherwise, keep demand down.

5.3.1 Misunderstanding

The expression of need for a service depends on an individual's awareness of the existence and character or suitability of that service (the experience of need might also depend on this). As Parker (1975, p. 208) argues: 'if people misunderstand the function of a service or do not know of its existence they are unlikely to apply'. Thus the withholding of information concerning the existence of a service represents one informal (intentional or unintentional) rationing strategy (Foster 1983). Rees (1972) terms this process *rationing by ignorance*, whereby services are deliberately not publicised. Failing to formally advise those with health needs that the rules of eligibility might not apply to them (see above) might also be included in this category.

The local authority survey shows that most housing departments are reluctant to advertise the existence of their medical priority rehousing schemes: less than half (49/117) of the authorities surveyed make documentary information on the housing services they offer to people with health needs, available to the public. The tenants' and applicants' survey shows that as a result less than one in five (145/836) applicants learn about medical priority from the housing department itself.

The reluctance to advertise welfare services is usually justified by the assumption that those really in need will eventually, in any case, learn of their existence (Parker 1975). One housing manager in Hambley felt that most people in his authority in need of the medical priority rehousing service knew about its existence through word of mouth. Some housing departments, on the other hand, may limit information about their systems as a deliberate means of rationing demand. Forewell's housing department avoids publicising its medical priority system, for instance, not because it is convinced

that people are already aware of its existence, but because 'there are already too many medicals' [applicants with health needs].

Housing application forms play an important role in prompting those who have approached the housing department or association to express their medical needs. It is especially important therefore for those who, although having approached the housing department or association, may still be unaware of the availability of medical priority, that the forms encourage applicants to mention any health needs they may have. 87 of the local authorities surveyed made their general application forms available during the original study. On close inspection of these forms I found that 61 of them do clearly prompt applicants to mention and briefly describe any health needs. A further five ask applicants of any disability only. 21 forms, however, do not make direct reference to medical need. In these authorities applicants are usually invited to describe why they want to move or to mention factors that might be relevant to their application. They are not informed on the form that health needs constitute such a factor and may be taken into account in the assessment of their application, however.

Those local authorities whose application forms do not prompt applicants to mention their health or mobility needs include two of the case study authorities – Seaton and Artown. In these two authorities neither the new or transfer application forms ask specifically about medical needs. In both authorities applicants routinely come into contact with housing staff as their application is processed, but this does not guarantee that the relevance of their health needs will be explained to them.

It is the housing department's policy in Seaton to ensure contact between applicants and housing officials concerning the completion of housing application forms. Theoretically then, all applicants can be advised of the relevance of their health needs and encouraged to include them in the form. But it is not housing department policy to alert applicants to the existence of medical priority, and an applicant's chances of discovering this depend on the diligence and experience of housing officers and their ability to elicit every piece of information from the applicant that may help their case. Significantly, the tenants' and applicants' survey shows that households in this authority are less likely to find help from housing staff available. Over 40% (83/192) of applicants here had not received assistance when they required it, compared with a quarter (165/644) in the other two case study authorities.

Applicants in Artown – who are similarly not prompted directly to mention any medical needs on the general application form – are asked only why they are applying for rehousing. The purpose of this form is simply to collect enough information to allow home visitors to make an appointment with applicants and complete a more detailed form on the reasons for the rehousing request. Every applicant for rehousing on whatever grounds is given a home visit in which their needs can be discussed with housing staff. The application forms are screened and the information contained within them passed on to the home visitor. Home visitors are not, however, encouraged to prompt applicants to describe their medical needs if these have not already been mentioned.

In another of the case study authorities – Southplace – only the application form for new applicants makes direct reference to medical needs. The transfer form simply asks of the reasons for transfer request. Moreover, this form does not encourage applicants to approach housing staff for assistance.

In the remaining case study authorities, the general application forms do ask directly about medical problems. It is not clear however that they will always be successful in prompting applicants to mention any they might have. In Ingleburn and Southplace, for instance, the general application forms (only the application form for new applicants in Southplace) ask for any medical circumstances that *could affect the application*.. These forms do not offer applicants assistance from housing staff who could advise them of the relevance of their health problems. In Albury the application forms ask only for any 'disabilities, handicaps or special problems'. Since they are completed without the assistance of housing staff, it is clearly possible here too that those people who think their health problems are not included in this category might remain unaware of the relevance of these to their application, and might not express them.

In light of the above it is not surprising to find that the housing department is not the most common source of information concerning the existence of medical priority for prospective applicants. The tenants' and applicants' survey shows that most medical priority applicants learn about the relevance of their health needs to local authority rehousing applications through contact with health and social service professionals, especially their family doctor. Interestingly, despite the generally accepted view that existing tenants have a greater knowledge of how the council housing system works, this is as true for transfer tenants as waiting list applicants. This is especially the case,

moreover, in the authority – Seaton – that has no documentary information on the existence of medical priority and whose application forms contain no prompt to mention any medical needs the applicant may have. Here a third (65/192) of those interviewed said their family doctor had advised them of this, but only 10% (20/192) learned about medical priority rehousing through the housing department. In one sense this may be encouraging. What it means is that the health services are working with the housing services to promote health through housing interventions. But it also means that those whose health problems are already known to the health services are more likely to gain access to medical priority rehousing, thereby reproducing existing inequalities in access to health care. This might be particularly problematic for homeless people with medical needs (Robinson 1996; Stern & Stilwell 1991) and for those with mental health problems.

Whatever the reasons behind this process of limiting information supply, it has the effect of ensuring that people with equal needs in the same authority and between authorities will not have equal access to medical priority schemes, because they have unequal knowledge of their existence and relevance. Some evidence of this comes from a study of elderly applicants for rehousing in Dundee (Maclennan *et al.* 1983). Here those applying for and being awarded medical priority were not in greater medical need than those not applying for rehousing on these grounds nor than the elderly population at large.

5.3.2 Deterrence

People in need of a service, even when they are aware of its existence, may be deterred from expressing their need for it. Researchers have long been concerned with the way individuals balance their need for a service with the inconvenience of applying for assistance, particularly where that involves travelling to the centre of provision. Research has concentrated on the uptake of health services and has shown that, irrespective of need, this declines with travelling distance and cost, time and inconvenience of travel (see Curtis and Taket (1996) for a review of the literature). Official-looking buildings (Parker 1975) and the attitude of staff (Foster 1983) – what Lidstone (1994, p. 465) calls the 'service image' – can also deter individuals from applying for welfare assistance. Research has shown how, in the housing context, homeless people have been deterred from applying to their local housing department for accommodation by unsympathetic, unhelpful and sometimes rude, housing

officials (Watson & Austerberry 1986). This work also highlighted the way that a negative image of the public housing system and the stigma attached to being housed within it, also deterred people from approaching their local housing authority. The increased residualisation of the social housing system, and council housing in particular, and the image of social renting as the 'second best' tenure or tenure of last resort, has undoubtedly increased the stigma attached to living within the sector during the last two decades. Of course this might vary from area to area as the quality and size of the stock, as well as its history, similarly varies (see Chapter Two).

The data here do not contain any information on the deterrent effect of a negative image of social renting for those with medical need, nor how this might vary between the authorities surveyed, although large differences in the nature and character of the housing stock make this seem possible. The case study visits to nine housing offices did, however, highlight the differences in physical and psychological accessibility of the local authority housing department. For instance, all but one of the urban authorities – those we would expect to be served with better public transport systems – employ decentralised systems with one central office in the centre of the town or borough and a network of local neighbourhood offices (as many as forty in the largest metropolitan authority) distributed throughout the district. Applicants in the only centralised urban authority – Seaton – must usually visit the housing department in the centre of the borough. All the rural case study authorities have centralised housing departments with just one main office in the administrative town of the district. While this may be understandable in terms of the smaller sizes of the populations they are serving, it may make contact with the housing department difficult for (potential) applicants.

While it was argued above that limiting information supply concerning the existence of medical priority might be employed by housing authorities as a deliberate rationing strategy, there is also evidence that housing departments might deliberately attempt to deter potential applicants from expressing their (health) need by advising them in information leaflets and booklets of their limited chances of securing a medical priority award. Just three of the case study authorities had information available for those with health needs. On the one hand, Fordham's leaflets encourage people to approach the housing department and are optimistic that help will be available. People with health-related housing needs in Albury and Hambley, on the other hand, are advised that due to shortages of accommodation, only a limited number of applicants with *serious* illness or disability will secure a move on these grounds. Similarly, the application

forms in these two authorities advise that the council does not have enough housing to accommodate everyone applying for rehousing (on whatever grounds). Some people here may be deterred from lodging an application therefore in the belief that they will have a long wait to be offered a new home or may not secure a move at all.

The project found no evidence, however, of housing staff actively discouraging people who do approach the housing department from applying for medical priority at the first point of contact (though they may at a later point – see below). Although, as argued above, they may withhold information on the existence of medical priority, the case study visits suggest that diligent housing officers can also prompt people to express their health need and to pursue a medical priority application even if they are pessimistic with regard to the applicant's chances of being rehoused. In other words, off-putting publicity can, to some extent, in some cases, be offset if contact is actually made with the housing department, by housing officials who often draw people in.

5.4 Accessing the medical needs assessment procedure

Simply expressing health needs, whether formally in a general application form or informally to housing staff, does not guarantee a professional assessment of them by the housing department or association. Many medical priority applications do not reach this point. This section is therefore concerned with the routes into and out of medical needs assessment for people with health needs approaching their local housing department. The information that follows is summarised in Figure 5.1.

One group whose health needs are rarely assessed for specifically medical priority status are the homeless. None of the case study authorities provide medical assessments for homeless people in the same way they do for other applicants with health problems. In only two authorities can homeless people access any medical assessment, though even here this is only in order to establish whether the applicant is vulnerable – and therefore entitled to accommodation as a homeless person – on health grounds. Thus although (homeless) housing officers in all the case study authorities say that health needs are an important part of a homeless person's housing application, there is no formal procedure to bring these to light and homeless applicants are, in effect, ineligible to apply for rehousing specifically on medical grounds. They can only qualify for rehousing through the homeless route and, as Figure 5.1 shows, do

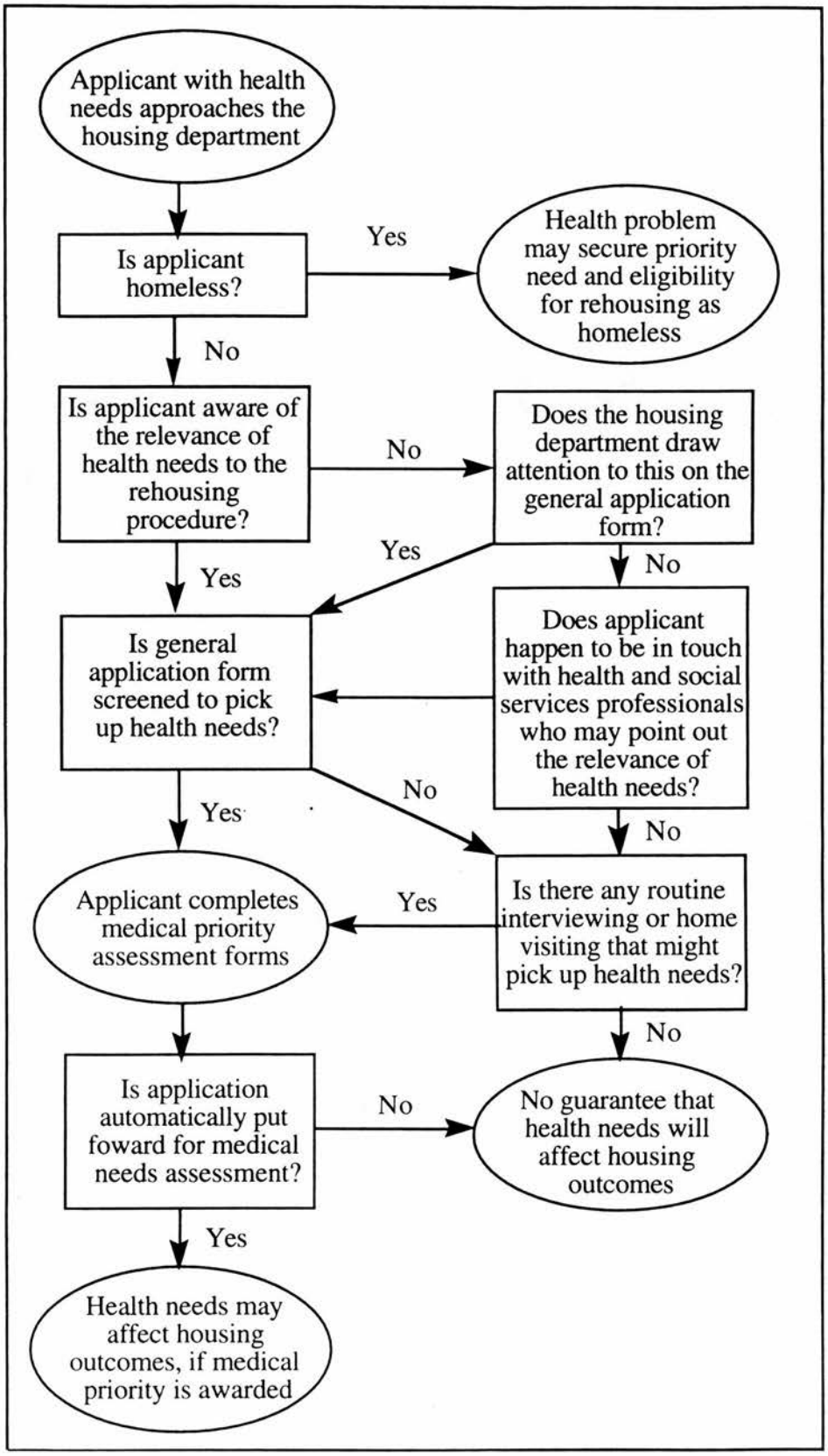

Figure 5.1 Routes into and out of medical needs assessment

not have access to the favourable housing outcomes secured via the medical priority channel.

For those who are eligible to mobilise the medical priority system, in order that their medical needs can be assessed fairly, housing providers require detailed information on health problems and mobility difficulties to be submitted as part of the application. This usually involves the completion of a special medical form and/or a home visit by a qualified housing officer, in addition to, or in place of, the general application form that highlights a request for rehousing on any grounds. For instance, while 83% (97/117) of authorities and 94% (65/69) of housing associations require an applicant to complete a general rehousing application form (at least sometimes), just 18% (21/117) and 39% (27/69) respectively say that the information contained in it is sufficient to base the medical priority assessment. 42% (49/117) of authorities and 10% (7/69) of associations always or sometimes require applicants to complete a self-assessment form, 74% (86/117) and 90% (62/69) require them to accommodate a home visit. In this way, applicants are given the opportunity to articulate or describe in more detail themselves, on the form or to housing staff who will complete a report, their problems and needs. The majority of housing departments and associations also require that at least some applicants secure support for their application from a medical practitioner, usually a GP or hospital doctor. Together this information provides the basis for the formal assessment of medical need by the housing officer, housing manager, medical adviser or assessment team. It is thus important, as Figure 5.1 shows, once an applicant has expressed his or her need for medical priority, that advice is provided on how to further the application and on the procedures that must be followed in order to fulfil these application requirements.

In almost three-quarters (85/117) of the local authorities surveyed, all general application forms are screened for evidence of medical needs. As many as one in five (22/117) housing departments, however, never screen any forms. Furthermore, the application forms in 38% (44/117) of authorities do not make any reference to the procedures that should be followed by people with medical needs. What this means is that in more than one in ten authorities (14/117), applicants are not advised on how to take their application forward, and their completed general application forms will rarely, if ever, be checked for the mention of health needs. Applicants in these authorities may therefore mention health needs in their general application form, but still be excluded from mobilising the medical priority system simply because they are

unaware of how to take the application forward or because they are still unaware of its existence. The same is true, moreover, in 20% (14/69) of housing associations.

The detailed case study information – simplified and summarised in Figure 5.1 – provides an insight into the way that some housing applicants, having expressed a medical need to their local housing department, drop out of, or are forced to exit, the medical priority application process, and may not, therefore, have their health needs formally assessed.

In the one case study authority – Seaton – where applicants are not prompted to mention medical needs in the general application form, the form similarly does not mention the procedure that must be followed in order to apply for medical priority, which in this case, involves requiring the applicant's GP to write to the housing department. Thus whether or not an applicant takes the application forward depends on their prior knowledge or on the advice given by housing staff when completing the form. It seems that not only can housing officers here discourage applicants from attempting to mobilise the medical priority system by offering an (uninformed) assessment of the likelihood of securing priority, but they do not always advise those who do wish to lodge the medical priority application of the need to provide supporting information from their GP.

The mention of health needs in the general application form is similarly not enough to initiate the medical priority process in another of the case study authorities. Applicants in Forewell must specifically request a medical assessment form; there is no automatic referral. Applicants are not advised of this anywhere on the general application form or in any information made available to the public. And while assistance from the housing department is offered on the form, on the whole applicants tend to fill the form in themselves, meaning there is little opportunity for them to make their needs known to housing staff who might then prompt them into requesting the additional medical form. What this suggests is that those applicants who know the system best or are known to the staff may be given the form, while those less well-informed may not proceed past this stage. Here too, a medical priority application will not be put forward for assessment unless a GP's note is included, but at least the medical assessment form asks for the GP's address and housing staff always approach him or her directly. On the other hand, those medical priority applicants who do not specifically request ground floor accommodation, will also not have their application forwarded to the

medical adviser. This is related to the belief that only those with mobility problems who need a change of floor level are really in need of a medical priority move.

Every applicant for rehousing on whatever grounds in Artown is given a home visit. The general application forms are screened and the information contained within them passed on to the home visitor. But it is entirely up to the individual to ask for a medical assistance form, even if they have already mentioned health needs on the general application form. Everyone who asks for a form will be given one. However those who have mentioned health needs on the general application form, but not directly asked for the medical assessment form, may not.

In some authorities all medical priority applicants must complete a general application form and it is on the basis of the information provided in the application form that (some) applicants are invited to proceed to the next stage of the application procedure. It is in this way that in two of the case study authorities – Southplace and Ingleburn – the number of applicants with health needs who will reach the formal assessment stage of the medical priority procedure are reduced. In Southplace housing officers make discretionary judgements about which applications might be successful and arrange for a home visit. Letters of support from health professionals or social workers usually persuade officers to interview those they are unsure about. But if there is no supporting evidence, the officer might simply file the application away and wait to see if any arrives at a later date. Unfortunately, applicants are not formally told of the usefulness of a doctor's note. Housing officers do tend, however, to interview most – though not all – of the applicants who mention medical factors on their form, even if in doubt. But it is worrying how much depends on individual officers as to whether or not, on the basis of this limited information, they will arrange a further interview, especially since in this authority the application forms may be unsuccessful at prompting applicants to mention any health needs (see earlier). Some officers also appear to have definite opinions on which cases should and which should not be interviewed, though these do not always relate to housing department policy on eligibility for medical priority. This usually relates to whether or not the type of medical need is 'deserving' of a medical priority award (a point taken up in more detail in Section 5.5.3).

Housing officers in Ingleburn also base their decision of whether to arrange a medical priority home visit on the information included in the general application form, but in this case, not the medical information. Once completed, the application form is

returned to the housing department where the points total *excluding* any possible medical or other discretionary points, is calculated from the details given. If an applicant does not accumulate a set number of points, and is unlikely to do so even with the addition of medical points, they will not receive a home visit, and their application will not proceed to the next stage of the medical priority procedure. This means that even though their health and mobility problems might qualify them for medical points, those applicants who do not accumulate enough points for other reasons, will not have those health needs assessed. Thus this could mean that someone with severe health needs but none or few other housing needs has less access than someone with less severe health needs, but a greater number of housing points. Moreover, since it is also in this authority that the questions concerning medical needs might not prompt some applicants to mention theirs, it is of course possible that an individual who has other housing needs and who accumulates the required number of points, does not mention their medical needs. In this way, they will not be invited to pursue a medical priority award, even though they would qualify for the medical priority home visit according to the housing department's own rules. Housing officers themselves expressed concern at the use of a points threshold to determine who they interview, but acknowledged that staff resources are limited and as a result, not all medical priority applicants can be visited.

Although it is most common for medical priority applicants in Hambley to request a medical assessment form themselves, they can first complete a general application form, where mention of medical needs should theoretically prompt the local patch manager to invite them for further interview. Here too, the patch manager can screen out applications he or she believes to be 'unsuitable' on the basis of the limited information provided – even though the housing department is fully aware that many people fail to complete the medical questions on the form correctly. Unlike in Southplace and Ingleburn, however, it is rare for a patch manager to do this.

In some authorities, all those who mention health needs to the housing department will, in theory, have these followed up. In Westplace for instance, all applicants for rehousing (on whatever grounds) must complete a general application form and are visited at home by the Environmental Health and Housing Officer. He screens all these forms for particular needs, such as those that are health-related, and always follows them up at the home visit (as well as providing the medical needs assessment). In Fordham, applicants with health needs can mention these on either a general application form or a special needs referral card and a home visit by the special needs

officer is automatically arranged. Applicants with health needs in Albury can similarly mention these in their general application form and on these grounds be invited to complete the medical assessment form, or they can simply request and be given the medical form which is completed with the help of neighbourhood officers.

In all those authorities (or associations) where contact occurs between the applicant and housing staff in the completion of medical forms or home visit reports, there is an opportunity for housing officers to screen out ineligible or unsuitable applicants, or to try and deter others who they think will not or should not be awarded medical priority from lodging their application. In some authorities – such as Hambley, Albury and Seaton among the case study authorities – housing officers are urged to do so by senior management.

In Hambley, the interview is regarded by management as important for the vetting and filtering of applications. To this end, interviewing officers are issued with guidelines, prepared by the medical adviser, as to who is eligible for medical priority. In Albury, housing officers are encouraged not to deter applicants from applying for assistance or from pulling out an application altogether, but to advise applicants of all the options and, sometimes advise them that they are only eligible for *in situ* assistance. The case study evidence suggests, however, that in these two authorities where housing officers are under pressure to filter out more applications for medical priority rehousing, this is a role they are reluctant to fulfil.

In other authorities – like Fordham and Ingleburn – housing officers informally deter applicants during the interview by making assessments of their chances of securing an award, by advising of waiting times and by making it clear they themselves will not support the application when the decision of whether to award priority is taken by the housing manager or medical adviser.

In just two of the case study authorities – Hambley and Albury – a further regulation of demand occurs. Housing managers and administrative assistants at the housing department and/or the medical offices can send the medical forms back to neighbourhood offices if they are incomplete or do not provide the type of information required. In Hambley, area managers must approve applications and complete a medical assessment supplementary form to voice their opinion on the suitability of medical priority rehousing before they are forwarded to the medical offices for assessment. Area managers can also withdraw applications altogether – a power that

housing officers are resentful of. In recent years the supplementary forms have been lengthened in a bid by the housing department to reduce the numbers of applications being approved. One area manager interviewed, however, said that he approves all applications on the grounds that, having completed all the procedures, applicants are entitled to have their needs met by someone with clinical qualifications. There is no guarantee, however, that all those applications forwarded to the medical office will be assessed by the housing department's medical adviser – indeed the majority will not. Clerks in the medical offices can remove forms which they believe will be unsuccessful – one estimated that between ten and twenty per cent of applications are removed at this stage. Once the forms have been passed by the clerks, they are considered by the assistant medical officer, who plays one of the biggest screening roles in the whole system. He claims to remove a further nine out of ten applications. Thus only a small minority of applications in this authority will actually be assessed by the official medical adviser.

What this section has tried to show is that there are a number of reasons why housing applicants with health needs may be prevented from mobilising the medical priority system and will not have their needs formally assessed, even if they have expressed those needs to the housing department. It has also highlighted the points at which they can exit the medical priority application process. Documenting this regulation of demand is important because it is usually informal, largely unaccountable and sometimes unrelated to need.

5.5 Needs assessment: who gets medical priority?

Despite the range of rationing strategies implemented by housing providers in the attempt to contain demand for medical priority rehousing, over two-thirds (81/117) of local authorities and three-quarters (52/69) of housing associations reported, at the time of the surveys, that demand for housing from those with health needs outstrips their supply of suitable accommodation. As a consequence, the evidence here suggests that housing providers attempt to ration the award of medical priority still further. Having negotiated the rationing barriers described, and reached the formal assessment stage, not all applicants will be awarded medical priority. Moreover, this also appears to be the case among authorities and associations who feel able to cope with the levels of demand.

The two surveys of local authority housing departments and housing associations did not ask about the proportion of medical priority applicants who successfully secure a medical priority award. It is not possible to establish therefore the extent to which demand is regulated at the formal assessment stage, nor how this might vary from one authority and one association to the next. Previous studies (in a limited number of authorities) have indicated that as many as 20–30% of those applying to their local housing department for rehousing on specifically medical grounds have their application turned down, though this varied from authority to authority (see for example Cole and Farries 1986; CRE 1984b; Howells 1984).

Just two of the nine case study authorities provided this additional information. During a three month period in Fordham in 1989, 743 applications for special needs priority were made on health grounds. Of those 554 whose outcomes were known, 295 (53%) were supported; 259 (47%) were not. In Hambley, over a three year period (1987 – 1989), 28,942 applications for medical priority were received by the housing department. Just 5,653 (20%) were granted priority. Thus, the information booklet available to potential medical priority applicants in this authority does not exaggerate in claiming that only one in six applications assessed by the medical adviser will secure priority.

While these two sets of figures seem a little on the low side in comparison to the earlier studies, it should, of course, be remembered that most local authorities are now less able to meet the housing demands – including health-related needs – in their district, as demand for medical priority has increased and/or supply of suitable accommodation declined (see Chapter Three). Both these case study authorities report that the demand for medical priority rehousing outstrips the supply of suitable accommodation in their district.

Although the evidence suggests that all local authorities regulate demand to some extent at this stage, clearly we might expect this to vary, at least in part, according to the capacity of the authority to meet demand for medical priority rehousing. Unfortunately I cannot explore this possibility. What I can explore, however, are the different ways that housing authorities do regulate demand in the assessment stage, and how decisions are made on who should and who should not be awarded priority.

Even among housing authorities and associations where demand for medical priority rehousing is matched by the supply of suitable housing, applicants must still have their

needs assessed. Assistance is allocated in principle according to some definition of need – 'normative' or professionally-defined need – and not expressed need, demand or want. The surveys of local authority and housing association housing managers and local authority medical advisers show that those dispensing medical priority have clear ideas about what, in principle, constitutes need for medical priority rehousing. Evidence from the case studies suggests, however, that the discretionary and informal judgements of housing officers, housing managers and medical advisers might also serve to favour some groups of applicant at the expense of others. Preliminary analyses of the tenants' and applicants' survey (Smith & Alexander 1992; Smith, Alexander & Easterlow 1997) have shown that as a consequence of these judgements and decisions, some groups with health needs fare better than others in securing a medical priority grading, in the country as a whole.

In regulating demand for rehousing from those with a range of housing needs, Spicker (1987) claims that housing managers draw on a set of shared ideas and values – what he calls an ideology of need – as to whose needs should be met. Smith & Mallinson (1997), on analysing the case study information of the national medical priority study, were similarly able to recognise a number of consistencies in the way that different groups with health and mobility needs are dealt with from housing department to housing department. Local analysis of the tenants' and applicants' survey shows, however, that the groups securing priority differ from authority to authority. What this means is that not only are some needs more successful in securing medical priority in a single district, but that the same needs might be awarded priority in one area but not in another. In other words, the same values may serve to favour different groups in different locations.

The remainder of the chapter seeks not only to document these variations and identify the factors associated with success and failure in securing medical priority both within and between authorities, but to understand and explain them. Here, four factors that appear to be related to the outcome of the formal medical priority assessment process are identified. They include the perceived relevance of the applicant's health needs to rehousing solutions, the way these needs are presented for assessment, applicants' 'desert', as well as need, of rehousing, and any other possible routes to rehousing open to them. These factors will be considered in turn.

5.5.1 Health needs and their relevance to rehousing solutions

Two fundamental assumptions of all medical priority systems are, firstly, that an individual's housing need is, at least partly, related to the relationship between their current housing situation and their health condition, and that a move would be beneficial in health or quality of life terms (Connelly & Roderick 1991), and secondly, that it is possible to weigh health needs against one another to ensure that those in greatest need are awarded priority.

Although, as argued in Chapter One, rehousing might, in theory, be thought to have a range of therapeutic and palliative effects for people with a wide range of physical and mental health problems, Table 5.1 suggests that, in practice, the medical priority system caters in most part for people whose health needs affect their use of their dwelling, or are caused or exacerbated by the current home and for those whom

Table 5.1 Relationship between housing and health and eligibility for medical priority

Relationship renders applicant eligible for medical priority	Local authorities (%/117)	Housing associations (%/69)
Poor health affects use of dwelling	93	97
Dwelling may be making health worse	93	99
Rehousing would improve health	90	99
Housing is causing ill-health	84	88
Rehousing would improve access to care	69	94
Rehousing would improve quality of life	68	81
Suffering from a list of acceptable clinical conditions	48	41

Source: Local authorities survey; housing associations survey.

rehousing would lead to health improvements. Medical priority schemes, local authority schemes in particular, are less sympathetic, on the other hand, to people whose claims to medical rehousing are based on possible quality of life gains, or improved access to care (Hill *et al.* 1992; Smith & Mallinson 1997).

Within this eligibility framework, moreover, some types of health need are favoured at the expense of others. Although in the past medical advisers have raised doubts about the possibility of comparing the effects of qualitatively different diseases and disabilities in different individuals, and the same condition in different individuals, especially when their relationship with housing is under consideration (Bakhshi 1986; Muir Gray 1978; Muir Gray & Yarnell 1978), housing departments and associations continue to do this, and in a way that seems to consistently disadvantage some health problems, particularly those associated with mental illness. Thus although the majority of authorities argue that suffering from particular clinically-diagnosed illness or disability is not a sufficient basis for the award of priority, the result is that medical priority, as others have argued (Cole & Farries 1986; Gardner & Troop 1981; Hodgson 1975; Howells 1984), is largely dominated by the housing problems of those with a physical illness or disability.

Just one of the case study authorities – Hambley – formally excludes certain health problems from consideration for medical priority, but all the housing departments and associations surveyed were found to formally exclude particular medical conditions, making some diseases and disabilities less likely to secure medical priority in the country as a whole. Most noticeably, as Table 5.2 shows, more local authorities and housing associations are willing to award medical priority to people with walking, mobility or vision difficulties than to people with mental illness or learning difficulties. It follows, therefore, as the tenants' and applicants' survey in three local authorities shows, that while households where at least one member suffers from walking, mobility or vision difficulties are over-represented among those awarded medical priority by between 3 and 10%, those households suffering from mental illness or learning difficulties are under-represented among this group by between 1 and 5%.

Evidence from the case studies suggests further that even in those authorities where the housing department reports formally to recognise mental health problems as valid indicators of housing need and eligible for medical priority status, that due to a number of informal beliefs and judgements – both deliberate and inadvertent – among housing

Table 5.2 Type of health problem and eligibility for medical priority

Disease or disability	Local authorities[1] Award medical points[2] (%/81)	Local authorities[1] Assign to medical priority queue or award priority label[3] (%/62)	Housing associations Award some level of housing priority[4] (%/69)
Walking difficulty	86	90	94
Other mobility difficulty	85	89	94
Visual difficulty	83	76	84
Hearing difficulty	61	31	54
Learning difficulty	61	24	57
Multiple sclerosis	77	84	91
Parkinson's disease	77	82	93
Arthritis	75	84	93
Cancer	75	77	90
Bronchitis	74	79	88
Emphysema	74	79	93
Mental illness	70	76	88
Neurosis	69	63	86
AIDS	63	52	87
ME	62	50	67

Source: Local authorities survey; housing associations survey.

Notes
1. Number of local authorities exceeds 117 because some authorities award medical points and assign people with health needs to a medical priority queue/award a priority label in another queue.
2. Column entries refer to those local authorities who ever award medical points and who award them to applicants with the given disease or disability.
3. Column entries refer to those local authorities who have one or more medical priority categories, or who award a medical priority label in other queues, and who say that the given disease or disability 'always' or 'sometimes' secures a priority label or a place in a priority queue.
4. Column entries refer to those housing associations with general needs housing stock who award priority on health grounds in their housing queues, and who say that the given disease or disability 'always' or 'sometimes' secures priority.

staff and medical advisers, individuals with physical health needs are favoured at the expense of those with mental health needs in a much larger number of authorities.

In seven of the case study authorities – all except Fordham and Seaton – mental health needs were observed during visits to the housing department to be considered less relevant to rehousing solutions than physical health needs and mobility problems, though not necessarily for the same reason.

Mental health needs, particularly depression, are amongst those formally excluded from medical priority in Hambley. Here, the medical adviser, together with the adviser in Albury and the home visitors in Ingleburn (who award medical priority) do not consider mental illness, such as stress or depression, to be relevant indicators of (re)housing need. In these authorities, the links between poor housing and mental illness are thought to be more tenuous, assessment of housing need on these grounds of mental illness is thought to be particularly problematic, and it is similarly more difficult to determine that a move will be beneficial. All believe that it is only in some rare instances when a change of accommodation will definitely be helpful. This is despite a wealth of evidence that housing and mental health are linked (see Chapter One) and that mental illness is susceptible to rehousing solutions (Elton & Packer 1987). Thus local analysis of the tenants' and applicants' survey shows that in Hambley, while those with walking or reaching/stretching difficulties are over-represented, households where at least one member suffers from mental illness or depression are under-represented among those securing medical priority. While in all 82% (63/299) of households surveyed in this authority secured a medical priority award, 87% (139/160) of those with walking problems and 84% (110/131) of those with reaching difficulties were awarded priority compared with 77% (90/117) and 76% (26/34) of those with mental illness and depression respectively.

In other authorities – especially those where the application procedure involves a home visit – applicants with mental health needs may again be at a disadvantage since the philosophy among housing officers seems to be that relevant health problems are those whose relationship with housing can be clearly *seen*. Home visitors in Southplace (who dispense medical priority) and Artown (who submit information concerning each application to the medical adviser) watch how people move around their home and in particular how they cope with stairs. The implication of this is that physical health problems, mobility difficulties in particular, are favoured because the associated housing needs are more obvious and can be more easily assessed.

In a further two authorities (Forewell and Westplace), mental health needs are not considered to be relevant to housing decisions, because housing managers in both

districts say that they lack suitable accommodation. In Forewell this reflects the fact that the only accommodation made available to successful medical priority applicants is ground floor accommodation.

Furthermore, although there was no clear evidence from the case study visit that applicants with mobility difficulties in Fordham are favoured in the needs assessment process, data from the tenants' and applicants' survey shows that this group are slightly over-represented among those awarded priority, while those without mobility difficulties are under-represented by as much as 22% ($p<0.05$). Since Smith, Alexander and Easterlow (1997) have already established that more successful medical priority applicants in this authority attain homes suited to mobility difficulties, as in Forewell and Westplace, the availability of suitable accommodation may be an important factor in this authority.

An important exception to the bias in favour of applicants with physical health needs at the expense of those with mental illness, is the remaining case study authority – Seaton. Here the medical adviser strongly believes that mental health problems are housing-relevant. Thus, in contrast with Hambley and Fordham where the reverse is true, applicants with mental health needs in this authority, are over-represented among those awarded priority, while those with physical health problems are under-represented. For instance, while 80% (75/94) of the total sample in this authority secured priority, as much as 92% (33/36) of those with mental health needs were among this group, but only 72% (42/58) of those with no mental health needs were. Once again, the availability of suitable accommodation may influence the needs assessment decision. Of all the case study authorities, Seaton council, as we shall see in Chapter Six, has the highest proportion of flatted dwellings – accommodation that may be particularly unsuitable for those with physical health needs and mobility problems if not on the ground floor.

Although the bias in favour of physical health needs and against mental health ones appears to hold in the majority of authorities, other definitions of what constitutes a relevant medical need and what does not vary widely from authority to authority, reflecting individual housing department policy or simply the opinions of those apportioning medical priority.

The medical adviser in Hambley always awards priority to those on dialysis and to those with sickle cell anaemia, while his counterpart in Seaton believes those with

AIDS and HIV and those with alcohol and drugs problems to be especially in need of a medical priority award. On the other hand, health problems formally excluded from consideration in Hambley include those relating to homelessness, domestic violence and housing conditions such as damp, condensation or overcrowding. These needs are not considered relevant to medical priority in this authority because they are argued to be catered for elsewhere in the housing system. Similarly, and for the same reason, in Albury medical priority will not be awarded for property defects, overcrowding or the need for support from relatives. The medical adviser in Artown will not award priority to those whose health needs are medicalised 'estate problems' (health needs relating to poor housing conditions or neighbourhood problems).

Although perhaps sometimes difficult to justify, this means of rationing the award of medical priority – according to the medical condition – is at least based on differentiating between health needs and on recognising the limitations imposed by the available housing stock. Other rationing strategies seem not to be designed to target the service towards those in greatest medical need or to those whose health problems are deemed to be relevant to a rehousing solution.

5.5.2 Presentation of health needs

5.5.2.1 Medical forms and home visit reports

In most local authorities and housing associations, individuals responsible for making the final decision concerning the award of medical priority do not themselves have direct contact with the applicant. They therefore require evidence of those needs, in the form of a self-assessment form, housing officer's/home visitor's report, and/or a health professional's letter. It is, in principle, on the basis of this information that the decision of whether or not to award medical priority is made. This suggests that it is not just the existence of supporting information that is important, but how a person's needs are constructed by themself, a housing officer and/or a health professional.

In six of the case study authorities (Albury, Artown, Fordham, Hambley, Ingleburn, Seaton) assessment of health need involves the review of medical forms and/or home visitor reports. Here housing managers and medical advisers emphasise the importance of the detail included in these. It is vitally important therefore in these authorities that the forms prompt and provide ample opportunity for the applicant to

articulate their needs or have them described for them. Assistance should also be available if required.

Among those local authorities that require applicants to complete self-assessment forms (n=48), over half (28/48) admit that applicants often find this problematic. For these applicants the availability of help and advice from housing staff may be an important determinant of the success of their case. Among the case study authorities, only in Forewell are self-assessment medical forms not routinely completed by, or with the help of, housing staff, though here the medical adviser awards priority to all applicants with support from their GP irrespective of the information supplied in the medical form. But in Albury, Artown, Seaton and Hambley, although it is housing department policy that all applicants should be interviewed by experienced housing officers who will help in the completion of the form (the general application form in Seaton), applicants can, if they wish, take the forms away to complete themselves. It seems likely that those forms completed by, or with the assistance of, experienced housing officers may be of a higher quality.

For those applicants who do receive assistance, and in those authorities like Fordham where all applicants are interviewed, the usefulness of the information supplied to the housing manager or medical adviser depends to a large extent on the motivation and competence of the individual interviewing officer, in both encouraging the applicant to reveal as much information as possible, and in recording the detail in a useful way. The medical officers and senior housing manager responsible for apportioning the medical priority awards in these authorities attach great importance to the information contained within the additional forms and say that it always has a bearing on their decision. The important factor here is not receiving assistance but from whom.

The case study information suggests that housing officers involved in completing medical forms or assisting applicants to complete them usually – though not always and not in all authorities – consider themselves to be advocates for the applicant, despite the pressure they feel, and resist, from senior management, to filter out applicants they think will be unsuccessful. They say they endeavour to ensure the forms are completed as fully as possible. But the quality of information contained within these forms – and as a consequence, the 'success rates' of individual housing officers – still appears to vary enormously according to the diligence and experience of the housing official.

For instance in Hambley the medical adviser says that he is influenced by the wording and presentation of the information included in the form, and that the quality of the evidence supplied is clearly linked to the time taken over the form by the housing officer. There is clear evidence here though of the differing levels of motivation to be found between housing officers, that result in great variations in the 'success rates' of their applications. One rather more diligent officer also complained that time constraints do not allow officers to treat all applications fairly and to spend as much time with each, as they would like.

The medical form in Albury includes space for the housing officer to make additional comments. These comments are, according to the medical officer, influential in her decisions, and yet it is not uncommon for forms to be sent to her with 'no comment' or brief information that is not particularly helpful. The doctor relies to a great extent on the housing officer's opinion, since this is the only point of contact with the applicant and the only information she receives that is not purely medical – she argues that her decision is as much a social one as a medical one. If the housing officer writes a full statement of support, it makes clear that they think the case merits an award. If, on the other hand, they make no comment, those in need cannot ever be distinguished from all the others.

In Artown transfer applicants are visited by their estate officers, while new applicants are interviewed by specially-trained home visitors. As the completion of the medical form is not a usual part of the estate officer's work, the forms they complete are known within the department to not be as comprehensive. Thus transfer applicants may well be at a disadvantage in making their needs known to the medical officer. Since she relies to a large extent on the information contained within these reports, the extra detail contained within a comprehensive report, can influence her decision. Thus here as in Hambley the medical officer remarked on noticeable differences between the quality of the forms, according to the experience of the officer.

Unlike in Hambley, Albury and Artown, housing officers in Fordham see their task as vetting out unsuitable cases. The Special Needs application form does not prompt housing officers to describe the need for medical priority in any amount of detail. It asks few questions directly about the medical needs of the applicants and how these impinge on their housing needs. The largest part of the form is concerned, rather, with the opinion and comments of the special needs officer. This clearly provides officers here with the opportunity to prejudice applications they do not support, and the

housing manager may be provided with more information on whether or not the officer thinks medical priority should be awarded than the medical needs themselves.

What all this means is that the articulation or 'construction' of health need, rather than simply the experience of it, may be an important determinant of the outcome of a medical priority application. Thus some applicants might find themselves disadvantaged in the needs assessment process, not because of factors associated with their health needs, but on the grounds that they are unable to articulate these needs, or fail to have them articulated for them, in a way that makes the application more likely to be successful.

5.5.2.2 Medical support

Over half (68/117) of local authorities and nearly 90% (60/69) of housing associations require information in support of at least some applications to be provided by health professionals – usually the applicant's own GP. And yet it is not always housing department policy to advise all applicants of this. What this means is that those who are informed or already know of the value of a doctor's note might be at an advantage given the extra weight this support might lend to their application. Indeed the tenants' and applicants' survey shows that the inclusion of a GP's note in a medical priority application can significantly affect its outcome. Those applicants whose GP does not write to the housing department, unlike those who do secure GP support, are under-represented among those awarded medical priority by as much as 20% ($p<0.05$). While 80% (75/94) of the whole sample who knew the outcome of their medical needs assessment in Seaton were awarded priority, just 61% (11/18) of those without medical support were successful.

In Forewell the provision of a doctor's note is enough to merit a medical priority award and in Seaton simply the *number* of medical letters may affect the outcome since the doctor here takes the number of letters to be a proxy for the amount of support an application merits. But in other authorities, the quality of the doctor's report may, like that of medical forms and home visit reports, affect a medical priority outcome. As we saw in Chapter Four, the value to housing departments of these letters varies enormously. Housing departments rarely make guidelines available to local GPs to ensure that their letters are relevant to housing managers or medical advisers (see Chapter Four). This is often – as in Hambley and Seaton – a consequence of the fact

that doctor's notes are not a formal requirement, in avoidance of the costs that would be incurred if they were. The medical adviser in Artown admits that she is only influenced by the support of certain doctors. She tends to disregard the opinion of those doctors she knows will write letters 'at the drop of a hat' and take more notice of those who she feels are more genuine. Support from a respected doctor is more likely to influence her decision.

5.5.2.3 External pressure

The survey of tenants and applicants found that in addition to completing medical forms, hosting home visits and/or securing a doctor's note as required, some applicants try to advance their application in a number of other ways. Such strategies include telephoning the council (n=148), visiting the council offices (n=208) and contacting a councillor (n=48). And it seems that for a limited number of people these strategies may tip the balance in favour of those applicants employing them, particularly where the case is borderline.

One administrative assistant working in the medical offices in Hambley said that she deals with many telephone calls from applicants asking for an explanation of their failure to secure medical priority. Sometimes she will pull out a file if the decision sounds 'strange', and she has been known to ask the medical adviser to take another look. All of the case study authorities mentioned the external pressure they experience – often from local politicians – to speed a case along or to provide assistance. Personal connections particularly with local political figures may be an especially important weapon in the bid to secure priority in rural authorities such as Westplace where intervention from 'powerful' friends has frequently been known to reverse a previously-taken negative decision. Housing officers in Fordham, Hambley and Seaton (all urban authorities) could also remember cases where the intervention of a councillor has led housing managers to change their decisions and award special needs priority on medical grounds when previously it had been denied. In Forewell and Seaton, 'special priority' awards have been dispensed at the discretion of senior management to a limited number of applicants with health needs, who are then spared the normal medical priority procedures, in order to avoid adverse publicity on the intervention of local councillors.

Only in Artown does the intervention of local politicians appear to have no influence over the medical priority decision. Here applicants and councillors and MPs themselves are advised that such intervention is a waste of time, as the housing department attempts to 'crack down' on such external pressure.

Smith & Alexander (1992) found from the tenants' and applicants' survey however that such strategies of application advancement are associated with a *reduced* likelihood of securing medical priority. They suggested that this might reflect the weakness of the applications of some those who are desperate to collate as much support as possible. Certainly among those employing such strategies and denied priority (n=66), the majority of applicants were associated with at least one of the range of factors described above or that will be described next that seem to reduce the chance of securing priority. For instance, half (34/66) suffered mental health problems, the majority (54/66, 84%) had no household member over the age of 65, most (54/66, 82%) had other housing needs and less than half (27/66, 41%) said that health needs were the main reason for requesting a move.

5.5.3 'Deserving' and 'undeserving' applicants

A further means of rationing the award of medical priority, unrelated to experienced or expressed medical need and its relevance to a rehousing solution, is based on who *deserves* to have their rehousing needs met. The issue of desert has been shown to impinge on decisions of whether to allocate resources in a range of welfare service areas, including social housing, particularly in the context of resource shortages (Foster 1983; Henderson & Karn 1984; Parker 1975; Scrivens 1982; Williams 1985). There is evidence from the case studies and the tenants' and applicants' survey used in this study that the moral judgements of housing officers, housing managers and medical advisers can significantly affect an individual's chances of securing medical priority in at least four of these local authorities, and in all authorities certain groups are looked on less favourably or sympathetically. Interestingly, though, those identified as being particularly 'deserving' or 'undeserving' can vary from authority to authority.

One group who appear to be widely favoured in the medical priority system are the older applicants. Although less than 10% (9/117) of local authorities surveyed said that it is housing department policy to award medical priority automatically on the

grounds of age, a quarter of medical advisers (22/89) say they always award medical priority to those over a certain age if they ask for it and get as far as the needs assessment. While this may relate to what some have called the 'medicalisation' of the problems of the ageing process, there is evidence that housing departments, like the public at large, believe that older applicants are more deserving of welfare assistance.

None of the case study housing departments award medical priority automatically on the grounds of age alone, but there is evidence that in at least four of them (Albury, Artown, Hambley and Ingleburn), those involved in the assessment of health need look favourably on this group. In two of these authorities, applicants over a certain age are spared from having to follow the normal, sometimes complicated, medical priority procedures because they would usually qualify anyway. Moreover, although no evidence was found of the favourable treatment of older applicants in Fordham, here too those over 65 were found to be over-represented among those securing medical priority by the tenants' and applicants' survey.

In Albury, the medical adviser argues that most applicants over the age of sixty would satisfy the criteria for being given a medical priority award because the average deterioration in health fitness, brought on by the natural ageing process alone, is sufficient to justify a move to warm accommodation on one level. As a result, a special OAP award was introduced which means that older applicants are no longer required to go through the official medical priority channel but can secure as much priority as younger applicants with medical needs, simply on the grounds of their age. Similarly, in Ingleburn elderly transfer applicants (unlike new applicants) are not required to have a formal medical assessment. Applicants are visited by housing officers who simply confirm a health need and priority is, in effect, automatically awarded. In Hambley the medical adviser will always award priority to the very old (those over eighty) if they have medical needs (data from the tenants' and applicants' survey confirms that this groups is over-represented among those who secure priority) and in Artown, while, as we shall see, the medical adviser tends to look unfavourably on applications from owner occupiers, this does not apply to older owner occupiers.

It follows therefore that older medical priority households are significantly over-represented among those securing priority, while younger households are under-represented. For instance, while 81% (538/665) of households surveyed who knew the outcome of their medical needs assessment were awarded priority, 87% (207/239)

of those with a member over 65 secured priority status, but only 78% (328/422) of those households with no member over 65 were awarded medical priority ($p<0.05$).

One group who are deemed to be 'undeserving' of medical priority assistance, on the other hand, are those whose demands on it are perceived to be unsubstantiated by their needs. In particular those who make 'unreasonable' demands for particular accommodation types or locations are frowned upon. The tenants' and applicants' survey shows that applicants requesting houses and homes with gardens are at a disadvantage in the assessment process compared with both those placing no restrictions on the type of accommodation they will accept and those who choose less popular or more readily available housing.

Applicants making such requests in Fordham were found to be particularly unsuccessful in their claim for rehousing. Housing officers in Fordham say that they will only support requests for priority if the applicants are willing to accept flats or maisonettes. They believe that requesting a house is 'unreasonable'. Applicants are advised that the housing department will take their requests into consideration when making the decision of whether or not to award priority. (Interviewing housing officers in Albury similarly admitted to including subtle hints in their reports to the medical adviser, if they do not think an applicant deserves priority on such grounds).

This bias against those placing restrictions on the type of home they will accept in Fordham is reflected in the findings of the tenants' and applicants' survey (see Table 5.3). While 21% (45/219) of applicants surveyed in this authority were denied medical priority, as many as 61% (11/18) of those who said they would only accept accommodation with a garden and 45% (18/40) of those who said they would refuse an offer unless it was a house, failed to secure priority. Applicants who placed no restrictions on the type of accommodation they wanted, on the other hand, were slightly under-represented among those denied priority (just 15% failed to secure a priority award). Similarly only 17% (6/36) of those requesting a flat were refused special needs status and just 9% (4/43) of applicants who favoured bungalows (single-storey houses) were unsuccessful.

In Fordham (though not Hambley or Seaton), the data also shows that applicants who try to avoid being allocated accommodation in difficult-to-let estates or who specify certain good areas that they would be prepared to move to, are over-represented among those denied medical priority (see Table 5.3). 38% (6/16) of the former group

and 32% (23/73) of the second, among those surveyed, failed to secure priority here. A particular headache for special needs officers in this authority is the number of people requesting a move to a popular neighbourhood in the district where the shortage of accommodation means that only homeless and transfer applicants will be housed there. A request to stay in one's own neighbourhood is, however, considered 'reasonable' even when the area is highly desirable: only 16% (10/64) of applicants who did not want to move from their current neighbourhood were denied priority.

Table 5.3 Medical priority outcomes and applicants' accommodation restrictions in Fordham.

Restriction	Outcome of medical priority application			
	Priority awarded		Priority denied	
	n	row %	n	row %
Require a garden	7	39	11	61
Require a house	22	55	18	45
Require a bungalow	49	91	5	9
Require a flat	94	84	18	16
Stay in own neighbourhood	54	84	10	16
Avoid poor estates	10	63	6	38
Specify good areas	50	68	23	32
No restrictions	17	85	3	15
All respondents whose application outcome is known	174	79	45	21

Source: Tenants' and applicants' survey

In some authorities any demands on the medical priority system from certain groups – even if they need to move on health grounds – are deemed unnecessary. For the same reasons that owner occupiers often find themselves ineligible to join their local authority's or a housing association waiting list (see earlier), those home owners who progress to the medical priority assessment stage may find themselves disadvantaged by a lack of support from housing officers compared to current local authority or

housing association tenants and private renters. The interviewing housing officers in Fordham and Ingleburn expressed the strongly-held belief that owner occupiers are able to 'help themselves'. They argue that priority should not be awarded to those who can afford to buy a suitable property for themselves, and they may refuse to support an application if they feel this to be the case. Similarly the medical adviser in Artown says she distinguishes between owner occupiers and tenants. She believes that if owner occupiers are really in need then they can, and should, simply sell their current dwelling in order to purchase something more suitable. Older people, though, will be considered no matter what their tenure is.

In all these cases it is acknowledged that applicants may have a genuine housing-related medical 'need', but because of their unreasonable demands, an implicit judgement is made that they do not 'deserve' to be rehoused under the authority's medical priority scheme.

5.5.4 Health problems and other claims to housing priority

Another means of rationing the award of medical priority interacts, again not with their medical needs, but with a range of other housing needs an applicant may have. Data from the tenants' and applicants' survey show that households with housing needs arising from circumstances other than, or in addition to, their health problems, are over-represented among those denied medical priority. People who ask for other housing priority needs to be considered as part of their whole application have a 12% greater likelihood of being refused a medical priority grading than those applicants whose only claim relates to their health ($p < 0.05$). Local analysis of the data shows this to be the case in *all three* participating authorities.

This phenomena is, however, particularly problematic for those applicants living in Seaton, and for transfer applicants in all three authorities. Applicants in Seaton are seven times (and 24%) more likely to be refused priority if they highlight other housing priority needs in addition to their health problems as part of their application, than those who do not ($p< 0.05$).

In all, transfer applicants with additional needs were found to be twice as likely as both their waiting list counterparts with other needs and other transfer tenants whose claim is based solely on health problems, to fail in their attempt to secure priority, if

they have other housing needs. 32% (63/200) of those transfer applicants with additional needs surveyed, compared with a survey average of 19% (127/665), were denied priority. Only 17% (23/139) of those waiting list applicants with other priority claims and 27/182, 15% of transfer applicants with no other needs surveyed, on the other hand, failed to secure medical priority.

Since more transfer tenants include a range of housing needs in their medical priority application, this might help to explain a further finding of the tenants' and applicants' survey that transfer tenants are, on the whole, slightly under-represented among those awarded priority, while waiting list applicants are over-represented.

The qualitative case study material helps to explain these findings. It suggests that while this type of rationing is common to a number of the authorities, the justification for it might vary between them. Firstly, health needs might be deemed to be a consequence of these other housing needs, and therefore, some authorities argue that they are not relevant to medical priority (though they may secure other kinds of priority in the housing queues). In Hambley and Artown, as we have seen, it is official policy that health needs relating to housing conditions such as overcrowding, damp and condensation or neighbourhood problems are not eligible for specifically *medical* priority. The medical advisers here complain of the 'medicalisation' of housing problems. Essentially, they argue, these are housing problems not medical ones, and as a result they are catered for elsewhere in the housing system. Reflecting this, in the three authorities included in the tenants' and applicants' survey (including Hambley), the discrepancy is particularly marked among those whose housing application relates to the poor condition of their present accommodation and/or to levels of overcrowding, in addition to their health problems.

Secondly, given the limited supply of healthy housing stock (and/or the quota restrictions on the number of medical priority awards that can be made), housing managers effectively 'reserve' medical priority gradings for those who have no other route into the housing system. Those who experience overcrowding or other poor housing conditions, for instance, will usually qualify for other kinds of priority in the housing queues on these grounds. In Hambley managers in the neighbourhood offices are required to fill in a medical assessment supplementary sheet in which they must indicate whether or not medical priority rehousing is the last resort. Similarly, in Albury, some applicants are not given the emergency award on medical grounds if it is considered they will secure rehousing via some other route. While this mainly applies

to OAPs (who are automatically eligible for a special award simply on the grounds of their age), it does apply to other applicants, especially those with housing needs in addition to their health-related ones. This practice maximises the capacity of the housing system as a whole to accommodate people with health problems, but it means that the beneficial outcomes associated with being awarded medical priority (see Chapter Six) are reserved for those who only have health needs, even if this means that some people with worse health problems end up with less housing choice, simply because they also happen to qualify for entry to the council stock via a different route.

A third explanation might relate to the concern of many housing departments to stop people 'abusing' the medical priority system. Housing managers and medical advisers continue to believe that people who request medical rehousing are primarily concerned with securing a better overall housing package (see also Aston and Gordon 1981 and Gardner and Troop 1981). Health needs, it is suggested, are included as a secondary consideration: people decide they wish to move and then gather as much evidence as they can – including ill-health – to advance their position in the housing queues. The senior housing manager in Hambley felt it was important to make it clear to the public that rehousing offers would be made through medical priority, only to advance health status, not to improve housing situation more generally. In Albury, both the housing manager and the medical adviser felt that too many people were abusing the system and viewed medical priority as a 'golden key' to rehousing. Moving people is very expensive, they argue, and so now the department looks first at how the applicant's current accommodation can be improved or made more suitable. If this can be done, applicants will not be awarded priority for rehousing. While this may save some people the distress of an unwanted move if their current home can be improved or modified, the rationale behind it appears to be to reduce the numbers being awarded medical priority rather than meet the applicants needs in the best way possible.

The data show that in fact very few medical priority applicants regard health problems as incidental to their bid for rehousing: over half (497/836) of those applicants surveyed in the tenants' and applicants' survey only wished to move because their health and mobility needs were so pressing, and most of the remainder (302/836, 36%) said that their health needs were just as important as their other housing needs in prompting them to apply for medical priority.

However, the data also show that those applicants with additional housing needs are less likely to say that their health needs are the main reason for requesting a move.

These applicants are under-represented among those securing priority. Those applicants who say their health needs are their main reason for lodging a housing application are, on the other hand, over-represented (and those who say their health needs are the main reason for a request to move home are more likely to secure priority). The fact that health needs are not the primary consideration does not automatically mean, however, that they are not severe enough to warrant a medical priority award. The problem here is that evidence of medical needs – even if supplied by a clinical professional – may be ignored simply because the housing department has decided that they are not 'genuine'.

Whatever the justification, however, what this means is that people with equal health needs are not treated equally and are not equally likely to secure medical priority. Moreover, those in greatest medical need are not necessarily most likely to be awarded priority on these grounds.

5.5.5 Inequity and the needs assessment process

This section has shown how the apportionment of medical priority is not necessarily, in fact is very often, not related to severity of health need. Inequitable outcomes both within and between authorities means that people in equal health need may not have equal access to the medical priority system and that those in greatest need do not always secure priority and cannot therefore queue for a home on medical grounds.

In fact, many of those who try, but fail, to secure medical priority may experience their health problems as acutely as those who are successful in their request for medical rehousing. The Nottingham Health Profile[1], for instance, does not discriminate between those applicants awarded and denied medical priority who have not (yet) moved. Those denied priority have similar scores to those awarded it, on the sleep and social isolation dimensions of the Nottingham Health Profile and they fare worse on the emotion dimension. They do, however, fare better on the energy, pain and especially physical mobility dimensions. In light of what has gone before, this might provide the key to understanding why they were denied priority.

The data also show important local authority differences. In Fordham, the Nottingham Health Profile does clearly differentiate between those awarded and those denied

[1] A well-known quality of life measure

medical priority. In this authority those awarded priority fare worse on all dimensions and have a higher overall score than those denied, and thus here severity of health need does appear to be an important determinant of outcome. In Hambley, those denied priority have a very similar overall score to those awarded it, but in Seaton, those failing to secure priority actually have a higher overall score than those who are successful. Reflecting earlier findings, while those securing medical priority in both Fordham and Hambley score significantly higher on the physical mobility dimension than those denied, those in Seaton do not.

What is also interesting is how those applicants in Seaton who are awarded medical priority have, on average, a much smaller total score than their counterparts in Fordham and Hambley, implying that in these two authorities, medical priority applicants must experience a greater severity of need before they are awarded priority.

Perhaps reflecting what might be termed the inequity or unfairness of some of the findings discussed in this section, a third of those applicants surveyed (223/665) were dissatisfied with the outcome of their application (i.e. with the award or denial of priority), and a quarter (173/665) thought they were treated unfairly relative to other people with the same kinds of needs, rising to 84% (107/127) and 61% (77/127) respectively among those denied priority. The local authority and housing association surveys show, however, that nearly 40% (45/117) of local authority housing departments and 16% (11/69) of housing associations do not allow such dissatisfied applicants to appeal against the medical priority decision. The medical priority system is not open to redress.

5.6 Conclusion: Inequity and access to medical priority rehousing.

This chapter has shown how, in the attempt to ration medical priority, local housing authorities and housing associations implement a range of formal and informal rationing strategies. Some of these strategies prevent or deter people from mobilising the system of medical priority rehousing; others restrict access to the medical needs assessment process; and yet others mean that some of those whose health needs are formally assessed are not awarded priority in the housing queues on medical grounds. Some of the rationing strategies are organised around the concept of need, but many are not. What this means is that people with similar health needs in the same authority,

or in different authorities, may not be afforded the same opportunity to enter the rehousing process. The opportunity to use rehousing to meet health needs is unequally distributed among people with health problems.

6

MEDICAL PRIORITY AND HOUSING, HEALTH AND QUALITY OF LIFE OUTCOMES.

6.1 Introduction

Chapter Five looked at the issue of gaining access to the system of medical priority rehousing for people with health needs. It described the barriers that households encounter and must overcome in the bid to secure a medical priority award; barriers erected by housing managers as they try to regulate demand. This chapter is concerned with the next stage in the process for people with housing-related medical needs: securing a move suitable for those needs, into or within the social housing system. In other words it will explore the effect of having gained access to the system and assigned medical priority status in the housing queues in the 1990s.

Previous studies conducted in the 1970s and early 1980s suggest that applicants with medical priority may be largely unsuccessful in their attempt to translate the award into a favourable housing outcome or a more favourable one than had they not secured priority. They have shown, for instance, that the award of medical priority in the council housing queues often fails to effect rehousing for the majority of households in the waiting list. In Bolton after three years 21% of people with medical priority were still not rehoused (Cole and Farries 1986). In Oldham, after a similar period, only half of those who had been given 'urgent' medical priority, had been offered a new home (Gardner and Troop 1981) and in Portsmouth, this figure stood at just 41% (Howells 1984). Moreover, in this latter authority, only 5% more applicants with medical priority than those without, secured a move. In Liverpool, 120 of 600 Special Priority Medical cases were found to have been waiting to move for more than six months (CRE 1984b).

Information on housing and health outcomes, while a little more promising, is nonetheless somewhat ambiguous. The Bolton study (Cole & Farries 1986) found that after two years over three-quarters of those applicants who had been rehoused under the authority's medical priority scheme were satisfied with their new home. Half of these, moreover, had experienced some medical improvement in their condition since moving. At the same time, however, nearly a quarter were dissatisfied with the accommodation they had moved into, half of these reporting that it was unsuitable for their disability. Elton and Packer (1986, 1987) in a study of the effectiveness of medical priority rehousing in securing improvements in mental health, found that those rehoused on medical grounds reported improvements in their health following the move. Those who did not move did not experience the same health gains. However, similar improvements were found among a group who had been rehoused on grounds other than medical need. One study of elderly medical priority applicants in Dundee (Maclennan *et al.* 1983) found that although the majority were satisfied with their new home and with the move in health terms, many were, nonetheless, dissatisfied with the location in terms of the risk of crime and distance from shops and family and friends. This affected their happiness with the move more generally, and their quality of life following it.

Despite both the pessimism of these findings and the rapid decline of the social rented sector that took place following these studies, data from the tenants' and applicants' survey in three English local authority areas conducted as part of the national medical priority study, suggest that a medical priority award *can* secure rehousing outcomes that are favourable in terms of housing quality, health and quality of life. While information does not exist on the speed of rehousing of households without medical priority in comparison, the data do show that over two-thirds (236/349) of those applicants securing a move on medical grounds in these three local authorities are rehoused within six months of learning of their priority award. Moreover, as described elsewhere (Smith & Alexander 1992; Smith, Alexander & Easterlow 1997), it is overwhelmingly the case that those moved under a medical priority scheme feel they have moved to a healthier home. Over 60% (220/349) of those households surveyed reported that their move was to a home in better condition than their last one and eight in ten (284/349) said it was to one more suited to the household's medical needs. In addition, medical priority movers perceive their quality of neighbourhood life to have improved following rehousing. Over half (191/349, 55%) of those rehoused felt safer and more secure in their new neighbourhood and 43% (150/349) said they experience a better sense of community spirit than before. Overall, more than

80% (284/349) of those rehoused through the medical priority system believed they lived in a neighbourhood better suited to their household's needs. Furthermore, while most applicants did not report a change in access to the statutory health services or sources of informal support, among those that did, the majority said it had improved.

It thus follows that most of those rehoused felt satisfied both with their new home (292/349, 84%) and with their new neighbourhood (291/349, 83%). As a result, the majority of people rehoused via the medical priority channel in these three authorities associate their move with an improvement in their general health (213/349, 61%) and, in particular, with an overall improvement in the quality of their life (288/349, 83%). Thus despite earlier findings the indications here are that, at least in these three local authorities in England, medical priority rehousing may still in the 1990s represent an effective health intervention and one that users themselves believe to be valuable.

Notwithstanding the promise of these findings, further data available from the same study suggest that having overcome the obstacles en route to securing a medical priority award, applicants must first negotiate a further array of rationing strategies in order to accrue the favourable housing and health outcomes described. The rest of this Chapter is concerned with the problems applicants face in translating their medical priority award into a suitable offer of rehousing. It draws largely on the information contained within the tenants' and applicants' survey and the case study material, linking these data sources, to show how and why most applicants with medical priority secure beneficial moves into or within the social housing stock , but not all do.

6.2 Queuing with medical priority

6.2.1 Queuing for a home

The decline of the social rented housing sector – particularly the council sector – over the past eighteen years has been combined with an increase in demand for accommodation not just from those with medical needs, but from households with a range of other accepted housing needs – most notably the homeless. This means that people with medical priority are increasingly competing with other needs groups for a declining housing supply of variable quality. This leaves local authority housing managers the unenviable task of managing the relationship between demand for

rehousing and the supply of housing in their authority. This is done in each local authority (and housing association) via a system of priorities and queues.

The waiting list is a common example of a secondary rationing strategy, employed by service providers throughout the welfare state (Parker 1975; Scrivens 1979). Managing demand in this way, by holding off needs until resources become available to meet them, in theory enables all those accepted to be in housing need to be accommodated (eventually). Waiting time might also, of course, act as a deterrent and a means of primary rationing – people having secured medical priority or had other needs acknowledged may be deterred from pursuing their rehousing claim by the wait they anticipate, and remove themselves from the housing queues. Certainly the 'drop-out' rate among homeless applicants housed in temporary accommodation waiting for a council dwelling has been shown to be significant (Lidstone 1994).

92 of the 117 local housing authorities surveyed were able to provide information on the size of their waiting lists: numbers of households waiting to move into, or transfer within the council housing stock ranged from 500 in one authority to over 55,000 in another. As a measure of the ability of the authority to meet this demand, the ratio of rental units to waiting list size varied from as much as 5:1 to as little as 1:3. Households with medical priority make up varying proportions of these queues. In two thirds (53/85) of those authorities that knew how many people were queuing with medical priority, they make up less than 20% of the waiting list. In approximately a quarter (23/85), between 20% and 40% of the waiting lists consisted of households having been awarded medical priority. One in ten (9/85) reported that those with accepted medical needs represented more than 40% of all those queuing in their authority.

Operating a waiting list of this kind is not a straightforward task. In the market place, customers are queued simply and relatively unproblematically according to ability to pay or on a first-come-first-served basis. It would be unacceptable in a welfare system to determine access to services according to need and then queue those in need according to ability to pay. Thus more equitable, just means of queuing people have been sought. Even then a number of options exist. People could be queued according to waiting time, but when some needs are greater than others this system might not be desirable. Thus although waiting time can still often afford applicants some degree of priority in the housing queues (over half (n=60) of the surveyed authorities continue to acknowledge waiting time in the housing queues in some way), housing departments

have recognised that in the interests of fairness, it is necessary to prioritise applicants primarily according to need. Having traditionally been afforded a great deal of autonomy in running their own housing queues and in determining how and who to prioritise, in practice they employ a variety of different queuing procedures. For instance, among those local authorities surveyed, over half (n=61) queue people in a number of different categories or lists. These usually relate to the route of entry to the housing system (i.e. as new applicants, transfer tenants or homeless), the required accommodation size or type of housing need. Applicants are then prioritised within these lists according to either points accumulated for need and/or waiting time. Sometimes these queues might in themselves represent priority lists. Just over one in five (n=26) authorities, on the other hand, employ points schemes alone, whereby those with the greatest number of points, and thus theoretically, greatest total need, occupy a position higher in the queue. The remainder use some other system including the use of priority labels in the general housing queue(s), merit schemes or a combination of the above.

The effect of such formal prioritisation (of any needs) is, in theory, to ensure that those individuals or groups with the highest overall priority – theoretically those in greatest need – are, at the point of allocation, offered accommodation ahead of those with less priority who are in less need. However, because housing allocations are essentially stock-led, getting to the top of the queue does not automatically coincide with a suitable home becoming available. At this point households encounter a series of both formal and informal practices and procedures at the hands of lettings officers whose task is to match individual applicants to the available housing stock. The effect is to differentiate between applicants who receive the *first* offers, and those who receive the *best* offers of accommodation. These rationing strategies, determining not only who gets anything ('secondary' rationing), but also who gets *what* ('tertiary' rationing), have become increasingly important in recent decades with the decline in quality of some parts of the housing stock and the emergence of difficult-to-let estates.

Lettings officers are faced with the day to day task of allocating vacant properties to those in the housing queues. Formally, this involves trying to accommodate those at the top of the queue (those with the greatest priority), matching applicants to dwellings that are suited to their needs, and minimising the length of time any property is unoccupied. Clearly these objectives may be incompatible, not least because dwellings do not usually become available in the order they are required, if at all. The task is complicated further by the pressure on letting officers to make the 'best' and most

efficient use of the housing stock. This involves letting as many properties as possible and as quickly as possible, maintaining the high standards of the best housing and neighbourhoods, and ensuring that dwelling are not under-occupied at the same time as people are homeless or live in overcrowded conditions (Henderson & Karn 1984; Spicker 1987).

In the context of a housing stock of uneven quality, when some properties and areas are more desirable than others, these objectives become at once more important and increasingly difficult to achieve. They clearly imply some form of differentiation among applicants in terms of who will be offered accommodation first and who will be allocated the best housing (and who the worst). Moreover, this often involves making decisions about which applicants are suited to which properties, not in terms of their needs but, in order to minimise refusals of offers, of what they will accept, whether they will be acceptable as prospective neighbours to existing tenants and, in the case of transfer tenants, the value of any resultant vacancy (Henderson & Karn 1984; Spicker 1987). Thus even in those authorities where strict guidelines concerning the allocation of housing exist, the distribution of housing resources depends to some extent – albeit, as the case study material suggests, greater in some authorities than others – on the discretionary decisions of individual lettings officers.

These secondary and tertiary rationing systems are encountered by all housing applicants and as such are not directed specifically at those with medical priority. Nonetheless, their effect is to determine both whether those with accepted health needs will secure a move and also what quality of accommodation they will be offered. The findings of the tenants' and applicants' survey suggest that the overall effect of these systems is to favour (at least some of) those with health needs, relative to people with other priority needs. This is what produces the favourable housing outcomes described above. To understand this we need to consider how medical needs are prioritised relative to other housing needs within the wider allocation system.

6.2.2 The prioritisation of medical needs

Medical needs have traditionally been recognised as one type of housing need that requires or 'deserves' priority in the housing queues (see Chapter One) and in the early 1990s, all those local authorities (n=117) surveyed continued to have in place

some form of medical priority system. Moreover, the majority of housing associations with general needs stock were also found to afford those with health needs some degree of priority in their housing queues. Reflecting the queuing system in operation, this priority is assigned in a number of different ways in different authorities as well as within them. Over two-thirds (81/117) of authorities award medical points, 44 (38%) queue households with accepted health needs separately in one or more medical priority queues, and 35 (30%) recognise health needs by way of a priority label in the general waiting list(s). Notwithstanding these differences, medical need continues to be recognised as a valid indicator of housing need throughout the social housing system.

The weight health needs should carry and the amount of priority that they should be afforded, has, on the other hand, long been an area of controversy and disagreement (Fisk 1984). Previous studies have indicated that they often carry little weight in council housing allocation systems and have little effect on rehousing chances, though the extent to which this is true might vary from authority to authority. In Oxford, the maximum five points available for medical needs contributed little to the overall points total of thirty required for rehousing (Muir Gray 1978), and in Portsmouth less than half of the number of points needed to reach the top of the waiting list could be secured on health grounds (Howells 1984). Thomas and Yarnell (1978) found similarly in Wales that, although the number of medical points available varied (from 13% to 60% of the total needed), again they were largely insufficient to ensure a move on health grounds alone.

The national local authority and housing association surveys employed here, on the other hand, show that medical priority *can* carry considerable weight in the social housing queues, particularly relative to other priority needs. For instance, in those local authorities where council housing applicants, including those with medical priority, are queued in separate lists (n=44), only those in the (statutorily) homeless list are consistently ranked above those with the highest available medical priority. In other words, only those households to whom housing departments have a statutory responsibility, are prioritised above those with medical priority. (Although the Conservative 1996 Housing Act abolished this legal mandate to find accommodation for the homeless, it has been re-introduced by the incoming Labour government). Half of these authorities (n=22) say that those with medical priority rank below the statutory homeless, though one in three (n=15) say the two groups are ranked equally and a further six say that those with medical priority are ranked above all other groups.

What this should mean in practice is that people with medical needs are among the first in the housing queues to be rehoused and are offered the pick of the housing stock.

Perhaps surprisingly, the increasing pressure the social housing system has found itself under during the past two decades as the council housing stock declined at the same time as demand from a range of needs groups increased, has not led to a reduced commitment among local authorities or housing associations to accommodating those with health needs. 70% (82/117) of local authorities and nearly half (31/69) of housing associations surveyed disagreed with the suggestion that medical priority carried less weight, at the time of the surveys, than it had done five years previously. Just 21% (25/117) and 17% (12/69) respectively agreed with the suggestion. As a consequence, in two-thirds (76/1117) of authorities and one-third of housing associations (25/69), people without medical priority are increasingly forced to queue longer relative to people with medical priority. What this means is that the decline of the council rented stock, and of the social rented stock as a whole, appears to have increased the discrimination among needs groups in ways that favour the medical priority channel in relative terms. The social housing system, it seems, has reserved enough priority for those with medical needs to ensure that they can continue to be rehoused.

One means of ensuring this has been to regulate demand from that needs group which is formally prioritised above those with medical priority – the homeless. If the formal priority assigned to homeless people were translated directly into allocations to this group in practice, some authorities would need to use all their vacancies to cope with the demand, and those with medical priority would never secure a move. The effect of a number of allocations procedures is thus to restrict the proportion of allocations that are made to homeless people and to remove the competition between homeless and medical priority applicants for the most desirable housing (Smith & Hill 1992). These procedures include the use of temporary accommodation, limiting the number of offers made to homeless applicants to one, the fast-tracking of urgent cases (although this is reserved for very small numbers of applicants), the reservation of certain parts of the housing stock for those with medical priority, and/or ensuring that homeless applicants can only queue for particular parts of the housing stock. What all this means is that the high levels of homelessness in some areas – particularly the London boroughs and large urban authorities – may not affect housing opportunities for those with medical priority as much as might be expected.

This means that people with health needs have higher housing priority than other rehousing applicants. As a result, and as Table 6.1 shows, in over one-third of those authorities employing different queues (15/44), applicants in the (highest) medical priority queue can always be rehoused, and in 21 (48%), they sometimes can. Similarly, in nearly two-thirds (54/81) of those authorities where medical points are awarded, waiting list applicants can accumulate enough points to secure a move, and the same is true for transfer applicants in 48 (59%) of authorities.

Table 6.1 The effect of securing medical priority in the local authority housing queues

Households in the (top) medical queue are rehoused:	n	% (/44)
Always	15	34
Sometimes	21	48
Rarely	8	18

Households with (maximum) medical points are rehoused:	Waiting list		Transfer list	
	n	% (/81)	n	% (/81)
Usually	54	47	48	59
Rarely	20	17	14	17

Source: Local authorities survey.
Note: Column totals do not equal 100% because some local authorities did not know the effect of securing medical priority.

The evidence suggests, moreover, that at the point of allocation, there are a number of further reasons why we might expect applicants with medical needs to be offered accommodation that is suited to their needs and that they find acceptable. Lettings officers, for instance, are usually informed of the types of property they must allocate to this group or at least advised of what offers would be suitable and which would not. Among the case study authorities, four require their medical adviser to make recommendations on the type and/or location of the dwelling required by the medical priority applicants whose cases they assess. In these authorities it is compulsory for

lettings officers to follow these recommendations. In the remaining authorities, medical priority applicants are visited at home by housing officers. This provides officers the opportunity to witness the housing problems and make a note of what dwellings and/or locations would be more suitable. This information is usually passed on to lettings officers (though sometimes in small authorities such as Westplace, visiting housing officers might also be responsible for making allocations), who, in seeking to minimise refusals try to offer the most suitable properties.(Of course, applicants do not always find the type of properties recommended acceptable.)

The high priority afforded to medical needs combined with the opportunity to refuse a number of unacceptable offers without losing their priority status, means that medical priority applicants accrue considerable bargaining power within the allocation system. Their position at the top of the housing queues means that lettings officers are under pressure to ensure they are rehoused as quickly as possible. But this depends not just on making them offers as quickly as possible, but on applicants accepting them. In a third (42/117) of those local authorities surveyed, new applicants and/or transfer applicants can receive an unlimited number of offers of accommodation. In less than a quarter (27/117) are they required to accept their first offer. From a housing management perspective, therefore, it makes more sense to offer the pick of the stock to this group in the first place, rather than make a less appealing offer and risk having it turned down.

What all this means is that the medical priority system may represent that part of the local authority housing allocation system most committed to providing a home that is suitable and is as acceptable as possible, rather than one that is simply vacant.

It is interesting to note at this point, however, that health needs do not appear to carry as much weight in the allocations systems of those housing associations surveyed. 9 of the 78 housing associations with general needs housing stock surveyed do not award any amount of priority in their housing queues on medical grounds. Moreover, among those that do, applicants with recognised health needs are not consistently ranked so highly in the housing queues as they are in the local authority sector. Once again the statutorily homeless are usually prioritised above those with health needs, but a range of other needs groups – such as local authority and social services referrals and those at the risk of violence, for example – are also likely to be ranked at least as highly as those with medical priority.

But notwithstanding such encouraging findings from the local authority sector, there is further evidence from this national study to suggest that the numbers of people securing the favourable housing and health outcomes described through social sector medical priority schemes might be lower than first appears. For instance, although medical priority carries considerable weight in most authorities, in some – including one of those authorities included in the tenants' and applicants' survey – it does not. In other words these outcomes might only accrue to the minority of medical priority applicants in some authorities. Moreover, the data suggest further that even in those authorities where medical priority can represent an effective rehousing strategy for the majority of those securing priority status, for others it may not. In other words, the potential benefits of a securing a medical priority award in the social housing queues are not universally available. Moreover, access to them might, once again, be largely unrelated to level of need. It is in this context that the remaining sections of this chapter will therefore be concerned with the issue of who, amongst those with medical priority status, gets what and why.

6.3 Securing a medical priority move

This section will explore the reasons why some applicants with medical priority may not secure a move into or within the local authority housing system. A number of factors are associated with the success or failure of a rehousing bid. These include area of residence, amount of medical priority secured, existence of other housing needs in addition to health-based ones, route of entry into the rehousing process and 'suitability' of applicants for particular tenancies. They will be considered in turn, describing how they affect chances of rehousing.

6.3.1 Area of residence

The emphasis so far has been on how medical priority status can not only improve the chances of rehousing and the speed with which it takes place, but can, at least sometimes, guarantee a move in most local authorities in England. But it is important to point out here that – albeit it in the minority of cases – it cannot and does not in all authorities. For instance, in 8 (18%) of those authorities who queue people with medical priority separately (n=44), this group will rarely be rehoused. Among those authorities employing medical points (n=81), waiting list applicants with maximum

medical points will rarely secure a move in 20 of them; the same is true for transfer tenants in 14 authorities (see Table 6.1). This suggests that area of residence is a vitally important factor in determining the rehousing chances of those with medical priority.

Local authority differences in the size and quality of the social rented stock – both local authority and housing association – play an important part in determining housing opportunities for people with health needs. This may be reflected in the extent to which demand from this group is regulated earlier in the process, but the evidence here suggests that housing opportunities for those with medical needs depends largely – and varies geographically – according to the weight that medical needs carry relative to other housing needs, particularly homelessness, especially when demand on these latter grounds are high.

This point is demonstrated well by the nine case study authorities. Table 6.2 shows how chances of being rehoused via the medical priority channel vary widely between these authorities, primarily according to the degree of prioritisation – both formal and informal – of people with medical priority relative to other needs groups, particularly homeless people.

In three of these authorities – Ingleburn, Southplace and Westplace – the number of medical points available ensures that those with medical priority occupy a position at the top of the waiting lists – alongside the homeless (and in Westplace, a number of other needs groups). All these groups of applicants can be considered for any vacancy. Thus low levels of demand from homeless people and the equal ranking of homelessness and medical priority means that medical priority can usually secure rehousing in these authorities.

In a further four authorities – Albury, Fordham, Forewell and Hambley – the points available to those with medical needs in effect prioritise this group above all other applicants except the homeless. All four, however, employ procedures to regulate demand from the homeless. Only Forewell does not make use of temporary accommodation for homeless households, though, together with Hambley, it does reserve a subset of its housing stock for those with medical priority. Ground floor accommodation can only be allocated to those with medical priority in Forewell and in Hambley homeless households cannot be allocated houses, which effectively means these properties will go to those with medical priority. This means that although

Table 6.2 Health needs and the housing system in nine local authorities

Case study authority	Formal ranking of medical need in the housing queues	Is demand from the homeless regulated?	Pressure on the housing stock from the homeless	% of all lettings made to the homeless	Demand for MPR and supply of suitable housing	Will medical priority usually secure re-housing?
Albury	Only homeless ranked higher	YES: Bed & Breakfast	Medium	39	Demand > Supply	YES
Artown	A range of other housing needs including homelessness secure greater priority	YES: Hostel	High	26	Demand > Supply	NO
Fordham	Only homeless ranked higher	YES: Bed & Breakfast	High	27	Demand > Supply	YES
Forewell	Only homeless ranked higher	YES: Cannot be allocated ground floor accommod-ation	Medium	31	Demand > Supply	YES
Hambley	Only homeless ranked higher	YES: Bed & Breakfast and homeless cannot queue for houses	High	33	Demand > Supply	YES
Ingleburn	Only homeless ranked higher	YES: A target of one in three allocations must go to groups other than the homeless	Low	11	Demand > Supply	YES
Seaton	TL: homeless ranked higher WL: a range of other housing needs secure more priority	YES: Bed & Breakfast	High	53	Demand > Supply	NO
Southplace	Ranked equally highly with homeless and other needs groups	NO (though ground floor accommod-ation often reserved for medicals)	Low	22	Demand > Supply	YES
Westplace	Ranked equally highly with homeless and other needs groups	YES: Bed & Breakfast	Low	24	Don't know	YES

Sources: Case study visits; local authorities survey; DoE HIP1 returns 1991.
Notes: TL = transfer list; WL = waiting list.

pressure on the housing stock from homeless people in two of these authorities (Fordham and Hambley) is relatively high, allocations to this group are lower than might be expected. Applicants with medical priority can thus usually be rehoused on health grounds alone in all four authorities.

By contrast, in the remaining two authorities – Artown and Seaton – the lack of weight carried by medical needs in the housing system combined with high pressure from the homeless means that applicants with medical priority in both these authorities are rarely rehoused on these grounds alone. For instance, at the time of the study, a maximum of 60 points were available for health needs or mobility difficulties in Artown, while the minimum required to qualify for rehousing was 200. Nor do health problems necessarily secure high points totals compared with other types of housing need. Indeed, more points can be secured for a range of other needs, particularly in Artown. Here, for instance, as much as 200 points can be awarded to tenants under-occupying a council house or maisonette, and to families with children living in multi-storey flats. A maximum of 90 points are also available for overcrowded households. Although medical needs carry slightly more weight for those queuing in the transfer list (see Section 6.3.4), similarly, waiting list applicants in Seaton can secure a maximum of 25 medical points, though they needed 45 to reach the top of the list. In Seaton the housing department is clear about its limited commitment to accommodating all other groups than the homeless. Thus although pressure on the housing system from the homeless is of a similar degree (similarly high) in this authority as it is in Fordham and Hambley, DoE HIP1 returns show that the proportion of lettings allocated to this group varied from approximately one-third in these two authorities to over one-half in Seaton during the year period to April 1991 (at the time of the study).

What all this implies is that the opportunities for people awarded medical priority, particularly in those districts where the housing system is under intense pressure, relates most to the specific commitment of housing departments to meeting their particular needs.

It suggests, moreover, that the experience of those rehoused applicants surveyed in Seaton is not representative of all, perhaps even the majority, of households who secure medical priority here. It also explains why even those who do secure a move in this authority wait significantly longer to be rehoused than medical priority applicants in the other two authorities (Fordham and Hambley) ($p<0.05$). The tenants' and applicants' survey shows for instance that over a third (14/40) of those who are

rehoused in Seaton must wait longer than a year to secure the move. This compares with just 9% (10/114) and 13% (26/195) of those rehoused in Fordham and Hambley respectively.

And, moreover, the findings of the housing association survey suggest that this part of the social housing system does not fill the gap left by the limited opportunities in the local authority sector in these two authorities. Although the supply of housing association accommodation is relatively large in Seaton (more than six times the national average), here, as in Artown, medical needs do not always secure rehousing by the housing associations surveyed. For instance, applicants with accepted disabilities or illnesses will rarely, if ever, be rehoused on these grounds alone in 6 of the 14 housing associations with general needs stock surveyed in Seaton. In Artown, disability will not ensure a move in 5 of the 17 associations surveyed and other medical problems will not in 8 of them. Thus people with health needs have limited access to housing suited to their needs in the social sector in some local authorities in England.

While area of residence is clearly, therefore, an important determinant of the rehousing chances of those with medical needs as a group, the data here suggests that a number of other factors impact on the chances of individual households within this group, within a single authority. These factors determine both an individual medical priority household's formal position in the housing queue relative to other households with medical need (and households with other types of housing need) and their chances of being offered a vacancy when lettings officers must choose between a number of different applicants both with and without medical need of similar overall priority status. These factors serve to favour some medical priority applicants over others. In other words, people with medical priority are prioritised not just relative to people with other housing needs but – whether formally or informally – relative to one another as a means of rationing not just the medical priority award but medical priority *rehousing*. The remainder of this section will explore these factors and determine their effects.

6.3.2 Level of medical priority

As one means of prioritising people with medical priority relative to one another, most local authorities grade their medical priority award according to severity of health

need. In other words, the medical needs assessment procedure involves not just the differentiation of people with health problems according to who is in need of medical priority rehousing and who is not, but the differentiation of people in accepted medical need, according to the severity of that need. The rationale for this is to ensure that the most urgent cases – those who will, in theory, be awarded maximum priority – can be rehoused more quickly.

Data from the tenants' and applicants' survey show that this is the case. For instance, as Table 6.3 shows, waiting list applicants with maximum medical priority in 95 (81%) authorities and transfer tenants in 94 (80%) authorities, secure a faster offer of rehousing than do applicants with minimum medical priority.

Table 6.3 Rehousing consequences of being awarded maximum and minimum medical priority

Effect of securing maximum and minimum medical priority	Housing queue: Waiting list n	Waiting list % (/117)	Transfer list n	Transfer list % (/117)
Maximum priority secures a faster offer than minimum priority and minimum priority secures a faster offer than no priority at all	49	42	49	42
Maximum priority secures a faster offer than minimum priority but minimum priority has no effect on speed of rehousing	46	39	45	38
Maximum priority does not secure a faster offer than minimum priority but minimum priority secures a faster offer than no priority	3	3	3	3
No amount of priority affects the speed of rehousing	8	7	5	4

Source: Local authority survey
Notes: Number of local authorities does not sum 117 because those authorities that did not know the effect of securing priority and those authorities where the most important effects of securing maximum and minimum priority were not thought to relate to the speed of rehousing were excluded.

However the data show that not only do those with maximum medical priority secure faster offers of rehousing, but that the award of minimum medical priority may have little or no effect on chances of rehousing. In 46 and 45 of the above authorities, minimum medical priority does not increase the speed with which rehousing takes place for those waiting list and transfer list applicants respectively who have secured it compared with applicants who have no amount of medical priority.

What this in effect means is that the grading of medical priority serves as a means of rationing medical rehousing. People may be assigned medical priority, but few will given the opportunity to take advantage of the housing (and health) outcomes described in Section 6.4.

In light of all this it is particularly worrying that numbers securing maximum priority are small, that some diseases and disabilities are more likely to secure one grade rather than another and that it is not always clear why applicants are awarded one level of priority rather than another,

Three of the case study authorities (Artown, Ingleburn and Seaton) grade their priority awards and in another (Albury), the medical adviser suggests different levels of medical severity, although the final award by the housing manager is not graded. The senior housing manager interviewed in Ingleburn rather disturbingly did not know the effects of securing one level of priority rather than another. In Artown maximum priority can secure a faster offer of rehousing for both waiting list and transfer list applicants, though minimum priority has no effect on the speed with which rehousing takes place for either group. The same is true in Seaton for transfer list applicants only. No amount of medical priority affects rehousing opportunities for waiting list applicants.

In Ingleburn, less than 5% of those awarded any amount of medical priority receive the maximum grade. Approximately 50-55% secure medium priority and the remainder are awarded the minimum level. In Artown, the 'special medical' award of 300 points – the only award that can secure those with only health needs a quicker offer of rehousing – is rarely allocated, perhaps a maximum of twenty times a year. Virtually all those securing priority are awarded one of a standard twenty points, a medium forty points or a high sixty points and these will have no effect on housing outcomes (unless supplemented by other points). The impression among housing department staff in Seaton is similarly that very few people are awarded maximum

priority, slightly more medium priority, and that the majority get the lowest priority available. What this means, if repeated throughout the rest of the country, is that the proportion of people with medical priority actually securing a move may be considerably smaller than earlier findings suggest.

Among these four case study authorities, in only one – Ingleburn – does the housing department provide guidelines explaining in which cases each level of priority should be awarded, and housing officers and medical advisers in all authorities except Seaton, and even including Ingleburn, could not explain their own decisions.

In much the same way that the award or denial of any amount of medical priority can be related to the type of health problem, so there is evidence that some illnesses and disabilities are more likely to secure maximum priority than are others, in two of these authorities. Mental health problems – already those less likely to secure *any* amount of medical priority in the country as a whole – are more likely, it seems, to be apportioned a lower priority grading than a high one.

In Ingleburn, the lowest band of priority covers things like stress, depression or very minor mobility problems. The first and second bands are reserved for those cases where 'housing aggravates the condition' and where a health condition could be 'relieved by a move' respectively. These are defined largely in terms of the extent or severity of mobility difficulties. Similarly in Seaton, where, as we saw, applicants with mental health problems are more likely to be awarded priority than those with mobility difficulties, it is rare for mental health problems to be awarded maximum priority. Here top priority goes to those with serious disability or disease and the elderly. Mental health problems, drug addiction and alcoholism, for instance, are more likely to be awarded a middle level of priority.

To summarise, in the majority of local authorities in England the issue for people with health needs is not simply one of securing a medical priority award, but of securing *enough* priority to be rehoused. This usually means a maximum medical priority award, which few people – particularly those with mental health problems – will secure.

6.3.3 Other priority needs

In Chapter Five we saw how applicants with other housing needs in addition to their health ones, can be less likely to secure a medical priority award, than are those with only health needs. Having secured priority, however, these same applicants may be at an advantage over those with only health needs at the point of allocation, in some authorities.

It was argued earlier, for instance, that queuing people in the local authority housing system according to the totality of their housing need represents one method of operating a waiting list that attempts to ensure rehousing for those most in need first. In six of the case study authorities (Fordham, Ingleburn, Artown, Albury, Westplace and Seaton) additional points, awarded for housing needs other than health ones, can be added to medical points. This means that these applicants might achieve a place higher in the housing queue(s) than others with the same health needs or same number of medical points, and in some cases those with more severe medical needs. In some authorities, therefore, people with health needs are prioritised relative to one another in the housing queues, not just according to their level of medical priority (see above), but according to the totality of their overall housing need.

The effect of these additional points may simply be to secure a faster offer of rehousing. But they could also conceivably mean the difference between an applicant securing a move and not. For all applicants in Artown and for waiting list applicants in Seaton, for example, the maximum number of medical points available do not alone qualify an applicant for rehousing, but points for other needs can tip the balance. In Seaton, other housing needs can also in theory secure a quicker offer for transfer tenants with medical priority.

Data from the tenants' and applicants' survey shows that people with a range of housing needs in addition to their health-related ones, do in practice secure faster moves in some authorities. Points for other needs cannot be added to those accrued on medical grounds in Hambley, and there is no evidence to suggest that in Seaton this makes a difference. In Fordham, however, applicants with other needs do appear to secure a significantly faster offer of rehousing ($p<0.05$). 59% (22/37) of people with medical plus other priority received an offer of rehousing within three months, compared with only 44% (41/94) of those whose only needs were related to their health. Furthermore, those whose health needs were their only claim to housing

priority, were 13% more likely than those with multiple needs to wait longer than a year to receive an offer. The nature of these other needs and the additional points available will determine how much faster offers are received.

6.3.4 Transfer tenants and new applicants

This process of affording extra priority in the housing queues to some applicants on grounds other than their health, can be especially advantageous to (some) transfer tenants with medical priority. Reflecting the findings of other studies of local authority housing allocation systems (Gray 1976; Means 1990; Spicker 1987), the evidence here suggests that transfer tenants with medical needs may be prioritised in a number of ways above those new to the sector when properties become vacant. This means that they can receive faster offers of rehousing.

In five of the case study authorities (Fordham, Artown, Forewell, Westplace and Albury) extra housing points are available to those tenants who are under-occupying their current local authority home, and these can be added to those secured on health grounds.

In fact, there is evidence to suggest that in eight of the nine case studies, tenants wishing to move to smaller accommodation, will receive special treatment at the point of the allocation. Family housing is in short supply in most areas and it makes good sense in housing management terms to create vacancies among this type of dwelling. Thus a transfer applicant who, if offered alternative smaller accommodation, would release a much needed dwelling, may be moved ahead of another applicant higher up the queue. Just one authority – Hambley – was adamant that transfer applicants will not be prioritised above new applicants in this way.

In some authorities, current tenants are favoured over waiting list applicants irrespective of the nature of the resulting vacancy. Further evidence from the case studies suggests that housing managers often feel that transfer tenants are more deserving of the offer of a move because they have worked their way up the housing ladder. They may also feel a greater sense of responsibility to their own tenants, especially when it is the council's accommodation that is causing ill-health or exacerbating existing medical problems.

In Seaton, where the housing system is under intense pressure from a range of needs groups, especially the homeless, in view of the severe shortage of accommodation the council openly chooses to prioritise transfer list applicants over waiting list applicants, and maintains only a small commitment to housing this latter group. Maximum medical priority therefore places transfer tenants in this authority close to the top of the housing queue but waiting list applicants cannot accrue enough medical points to make a difference to their rehousing chances. And thus while transfer tenants with maximum medical priority can secure a faster offer of rehousing than those with no priority, the same is not true for waiting list applicants with maximum medical priority. Here medical priority alone has no effect on rehousing chances. In Ingleburn, though the prioritisation of transfer applicants is not formalised, when properties become vacant, lettings officers who are obliged to consider applicants at the top of the homeless, transfer and waiting lists, admit that those on the waiting list are the last to be considered.

Reflecting such prioritisation of transfer tenants in the allocation of local authority dwellings in many areas, the tenants' and applicants' survey shows that in three of the case study authorities (including Hambley) among those rehoused, transfer tenants with medical priority receive offers of rehousing slightly more quickly than did new applicants. For instance transfer tenants were found to be 12% more likely than waiting list applicants to secure an offer of rehousing within six weeks of submitting their application, and 11% more likely to secure one within three months. It is unclear what the proportions of waiting list and transfer list applicants securing a move at all are. This might be particularly interesting information in Seaton.

What all this means is that route of entry to the medical priority system might be an important determinant of the chances of securing a move. People with health needs are more likely to be rehoused or be rehoused more quickly if they are already tenants of the local authority. In other words, people with medical priority may also be differentiated between according to their route of entry into the rehousing process.

6.3.5 Rural authorities and 'unsuitable' neighbours

We saw in Chapter Five how the intervention of local politicians can influence medical priority outcomes at the needs assessment stage. In rural authorities especially, it appears that local councillors may also influence allocations outcomes. Four of the

case study authorities are in predominantly rural districts and in three of these (Ingleburn, Westplace and Southplace) the opinion of councillors is always sought before allocations are made. In Westplace council members have the final say. In all these authorities, councillors are thought to provide invaluable advice on whether a household is 'suitable' for and will 'fit in' a particular village. Invariably this relates to their 'respectability' and 'reputation' according to local opinion rather than their medical need. An occupational therapist working for the housing department in Westplace finds it exacerbating that 'family tittle tattle has more importance' than her reports on the need and urgency of rehousing. What this means is that some households may constantly be turned down for vacancies that arise, or may be considered less favourably than other households for certain tenancies, on grounds no stronger than local unpopularity or ungenerous local gossip.

6.4 Translating a medical priority award into a beneficial housing outcome

Notwithstanding the greater problems some medical priority households face in securing a move, the majority of those that do so are rehoused in housing they associate with improvements in their health and/or quality of life. However, not all do so. This section is concerned with how and why some medical priority applicants secure more beneficial housing and health outcomes than others. Some important factors are determined and these include an applicant's area of residence, their route of entry into the medical priority system, their type of health need and the strategies employed in order to improve the offers of rehousing secured.

6.4.1 Area of residence

Local authority variations in the commitment of housing departments to meeting the housing needs of those with health problems suggest that even if people with health needs are rehoused their opportunity to secure good quality housing suited to their needs are considerably greater in some authorities than others. Similarly, the spatial unevenness of the council stock, in terms of not just its size, but type and quality, might imply again that even in those authorities where medical needs do carry significant weight in the allocation system, housing opportunities of this group also relate to the capacity of the local authority housing system to meet their (health) needs.

The tenants' and applicants' survey shows, however, that among three authorities in England with largely differing housing and medical priority profiles, the medical priority schemes in all three authorities can effect beneficial housing outcomes and health and quality of life gains for the majority of those rehoused and that differences, though not to be underplayed, are smaller than might have been expected. Clearly the housing stock variations and differences in prioritisation of medical needs are reflected most closely in discrepancies in the proportions of people in medical need in the authority who secure a move. Geography matters most in relation to the extent to which demand is regulated through the implementation of the primary and secondary rationing strategies described in Chapter Five and earlier in this chapter.

The tenants' and applicants' survey shows that it is overwhelmingly the case that those who are rehoused in Fordham, Hambley and Seaton believe their new council home is 'healthier' than their previous dwelling. The majority of households in each authority, as Table 6.4 shows, said that their new home is easier to heat, suffers less from damp, and is in better overall condition than the home they left.

Table 6.4 Improvements in housing and neighbourhood conditions following rehousing

	Local authority					
	Fordham		Hambley		Seaton	
	n	% (/114)	n	% (/190)	n	% (/40)
Home:						
Suffers less from damp	48	42	129	66	26	65
Is easier to heat	57	50	105	54	21	53
Is in better condition	65	57	129	66	26	65
Is in better state of repair	53	46	103	53	27	68
Is better suited to household's needs	100	79	159	82	35	88
Neighbourhood:						
Reduces risk of crime	47	41	101	52	14	35
Promotes sense of safety	67	59	129	66	23	58
Improves access to support	39	34	75	38	17	43

Source: Tenants' and applicants' survey

Few of those housing problems described in Chapter One as being potentially harmful to health remain after rehousing as Table 6.5 shows. Moreover, in all three authorities these are less widespread among those rehoused under medical priority than among all other survey respondents.

Table 6.5 Housing problems following medical priority rehousing

Major problem with dwelling	Local authority: Fordham n	Fordham % (/114)	Hambley n	Hambley % (/195)	Seaton n	Seaton % (/40)
Damp	5	4	26	13	6	15
Mould	5	4	19	10	3	8
Hard to heat	21	18	54	28	7	18
Draughty	20	18	41	21	9	23
Poor state of repair	7	6	39	20	3	8
Noise	14	12	9	5	10	25
Overcrowding	1	1	2	1	3	8
Lacks basic amenities	1	1	6	3	3	8
Poor design	11	10	23	12	5	13

Source: Tenants' and applicants' survey

The largest differences between local authorities relate to the type of accommodation secured by those rehoused under medical priority. For instance, as Table 6.6 shows, although flats are the most commonly allocated dwelling in all three authorities, these account for as much as 95% (38/40) and 75% (85/114) of dwellings received by those rehoused in Seaton and Fordham respectively, but only 42% (82/195) in Hambley. In this latter authority, more medical priority households are allocated houses, reflecting the housing department policy to reserve these for those with health needs, than in the other two authorities. Here over a third (74/195) of those households surveyed were rehoused in a house compared with only 16% (18/114) of households in Fordham and just 5% (2/40) in Seaton. Of course, these figures also relate to the wide variations in

type of housing stock owned by each housing authority, in particular the small number of houses in Seaton. For instance, just 1% of local authority dwellings in Seaton in 1991 were houses (compared with 49% in Hambley and 41% in Fordham) (CIPFA 1991).

Table 6.6 Type of dwelling secured through medical priority rehousing

	Local authority					
	Fordham		Hambley		Seaton	
Dwelling type	n	% (/114)	n	% (/195)	n	% (/40)
House	18	16	74	38	2	5
Flat	85	75	82	42	38	95
Bungalow	10	9	38	19	0	0
Hostel/Rehabilitation centre	1	1	1	1	0	0

Source: Tenants' and applicants' survey

In Chapter One it was argued that the relationship between the location of the home and the health of occupants might also be important. The data here suggest that medical priority rehousing also secures a move to a neighbourhood in which the majority of those rehoused feel safer and less at risk of crime and, for many, one that improves their access to informal social support (see Table 6.4) in the three authorities. Those rehoused in Hambley are especially likely to be happy with their new neighbourhood. Roden (1995) has already found that medical priority applicants in this authority are housed in slightly less deprived areas than those rehoused in the other two authorities.

Reflecting all these findings, the tenants' and applicants' survey also shows that those households securing medical priority rehousing associate moving to their new home with an improvement in their general health and overall quality of life in all three authorities (see Table 6.7). Some small differences do exist between the authorities. Rehoused medical priority applicants in Fordham are less satisfied with their move.

Table 6.7 Health and quality of life gains following medical priority rehousing

	Local authority					
	Fordham		Hambley		Seaton	
Rehousing associated with health gain in:	n	% (/114)	n	% (/195)	n	% (/40)
General health	57	50	130	67	26	65
Overall quality of life	83	73	172	88	33	83

Source: Tenants' and applicants' survey

Interestingly, applicants in this authority are rehoused in dwellings that are slightly 'healthier' and in neighbourhoods no more undesirable than in one of the other authorities. However the data suggest that medical priority households yet to be rehoused in this authority also live in more healthy homes and satisfactory neighbourhoods than their counterparts in the other two authorities. Thus the reduction in incidence of housing and neighbourhood problems is smaller here, reflected in the reduced numbers of people reporting an improvement in their house and neighbourhood conditions following rehousing. This tends to suggest that people who move to healthier homes and more satisfactory locations experience health and quality of life gains but which are in proportion to their improved living conditions.

What this means is that some local authority medical priority schemes are faced with a more difficult task than others in effecting health and quality of life gains, because these appear to depend, at least in part, not just on a household securing a good quality, suitable home in a desirable neighbourhood or a 'healthy' move, but the extent to which the new home and its location are 'healthier' than the previous one. And this might relate to factors (such as the condition of the private housing stock) that are out of the control of the housing authority.

Notwithstanding this point, the evidence reviewed here suggests that (at least some) medical priority households have access to the best, good quality and most suitable parts of the housing stock, even in authorities such as Seaton where, together with

shortages of such accommodation, the limited commitment to accommodating this group, suggests that few households with medical needs are rehoused.

However, the evidence also suggests that just as the prioritisation of medical priority applicants relative to one another in the housing queues affects their chances of rehousing or the speed with which rehousing takes place, so too it can affect the quality of the housing, and therefore the health gains, they secure. The rest of this section explores the way that people with medical priority are differentiated between at the point of housing allocation.

6.4.2 Previous housing tenure

The concept of housing-related health potential is also useful in explaining the finding that the health and quality of life gains secured through medical priority rehousing vary according to the route of entry into the social housing system. Table 6.8 shows that the chances of securing such gains through the medical priority system appear to be significantly greater for some tenure groups than others.

Table 6.8 Effects of securing medical priority rehousing by previous tenure

	L.A. tenant		Private renter		Home owner	
	n	% (/209)	n	% (/40)	n	% (/39)
Rehousing associated with improvement in:						
Housing conditions	134	64	31	78	24	62
State of housing repair	107	51	27	68	23	59
Risk of crime	108	52	20	50	13	33
Sense of safety	140	67	31	78	22	56
General health	121	58	28	70	21	54
Overall quality of life	169	81	37	93	29	74

Source: Tenants' and applicants' survey

Important differences exist as to the health effect of rehousing according to the previous tenure of those rehoused. For instance, 70% (28/40) of those applicants surveyed who had rented their previous home from a private landlord, compared with 58% (121/209) of those who had transferred from other accommodation within the council rented sector and 54% (21/39) of former owner occupiers, associated their medical priority move with an improvement in their general health. Similarly, 93% (37/40) of private renters compared with 81% (169/209) of transfer tenants and 74% (29/39) of home owners say this led to an improvement in their overall quality of life. Tenure group differences in how those rehoused perceive their quality of life to have changed are statistically significant ($p<0.05$).

There is nothing from the data to suggest that former private sector renters secure accommodation of higher quality, in better locations or more suited to their needs than do those applicants of other previous tenures. What the data do show, however, is that this group report the greatest *improvements* in their housing and neighbourhood conditions following medical priority rehousing. Table 6.8 shows for instance that those households who previously rented are most likely to consider their new home to be in better condition than their previous one, and to feel safer in their new neighbourhood, and the differences between tenure groups in their views on their new homes are statistically significant ($p<0.05$).

Although these variations in housing-related health potential do not reflect differences in the quality of housing that the different tenure groups receive, information from the tenants' and applicants' survey and from the case studies suggests that some groups and individuals among those with medical priority in a single authority are allocated less good housing and that this could affect their health opportunities. Their health potential might be limited by the unsuitability of the dwelling they are rehoused in.

6.4.3 Type of medical need

Further evidence from the case studies suggests that not only are applicants with mental health problems under-represented among those awarded medical priority and less likely than those with physical health problems to secure a maximum priority grading, but that they may also receive less favourable treatment at the point of allocation. In a number of the case study authorities, lettings officers admit they worry

about the reactions of existing tenants to moving an individual or household with mental health problems into the neighbourhood, and that this, in the attempt to avoid anticipated neighbour resistance, affects their allocations decisions. A case involving an applicant with mental health needs in Forewell illustrates this point well. The applicant was allocated a flat, not because it was most suited to their needs, but because it was located above a shop, and the applicant could not therefore cause problems for other tenants.

6.4.4 Homelessness and health needs

One group who do not fit easily into this discussion but whose plight nonetheless needs highlighting, are homeless applicants with health needs. Ironically, the corollary of restricting offers of good quality housing to homeless applicants in order to reserve them for applicants with medical priority, is that those homeless households with medical needs – even medical needs accepted by the housing department – are more likely to receive poor quality accommodation, unsuited to those needs.

This is because homeless households are often denied access to the medical priority channel (see Chapter Five). Even if their health needs are acknowledged and accepted by the housing department, these may not be translated into a medical priority award. At the point of allocation it is the most pressing aspect of housing need – that of being homeless – that is met. The philosophy among housing departments tends to be that once the authority has ensured the household has a roof over its head, once they have become tenants, it (the household) is then in a position to access and mobilise the medical priority system via the 'normal' route and the authority can begin to address their medically-related housing needs. Housing departments cannot do both at the same time it seems. As homeless applicants, households with medical needs cannot usually therefore access the favourable housing outcomes associated with a medical priority award.

The limit of one offer of rehousing (in three-quarters (88/117) of the surveyed local authorities, including 5 of the nine case study authorities) and thus the inability of homeless applicants to refuse any offers of housing, no matter how unsuitable, suggests that allocations officers will offer the poorest dwellings of their uneven housing stock to the homeless. They know that more or less any offer will be accepted by those who are most desperate. The fact and effect of only being allowed to queue

as an applicant with accepted health needs *or* as a homeless household is highlighted most effectively in the case of a young woman in Hambley. She had secured a medical priority award but before an offer of rehousing under the medical priority channel could be made, she became homeless and was therefore stripped immediately of her medical priority status. As a consequence she was moved to a temporary hostel before being rehoused permanently in a flat in an 'undesirable' area – the only type of accommodation made to the homeless in this authority.

Although all the case study authorities say they do try to ensure that the single offer of accommodation they make to a homeless household is as suited to their health needs as possible, housing outcomes for this group tend to hinge more on the dedication of individual housing officers than they do for those applicants with medical priority status. In only two of the case study authorities can (some) homeless applicants receive a formal medical needs assessment and only here do allocations officers automatically receive recommendations on the type of property required by the applicant. But even here numbers of applicants receiving these assessments are very small. Rather it is up to the motivation of individual homelessness officers firstly to encourage an applicant to mention any medical needs and secondly to make use of their own power or that of the housing department's medical adviser to make such recommendations. All local authorities are obliged by law to make a 'reasonable' offer of accommodation and it is this obligation that is employed by dedicated housing officers. In a study of homeless people with health problems in Edinburgh, Robinson (1998) found however that after approaching the local housing department, the majority of those interviewed had not been informed of the relevance of their health needs to their housing application and were still unaware of the existence of medical priority rehousing.

It is difficult to determine from the tenants' and applicants' survey whether homeless applicants with health needs do in fact receive less favourable housing offers than those queuing with medical priority, because, rather tellingly, such respondents are few in number (n=22). Robinson (1998) found that homeless people with health needs in Edinburgh were made offers of such bad housing that some of them preferred to remain homeless. The evidence here suggests that, although no less satisfied with their move than their medical priority counterparts, half (10/22) of those households rehoused by their local authority were allocated to a dwelling that they reported to be in a poor state of repair. This compares with only a quarter (83/327) of all other applicants.

6.4.5 Role of the applicant

The discussion so far has concentrated on the way that the social housing opportunities for those with medical needs are largely determined by the range of rationing strategies employed by housing providers in the context of accommodation shortages in most areas. Early studies of council housing allocation systems similarly focused on the housing department; on the power and discretion of housing providers in deciding who should get what. More recent studies have emphasised however that the housing applicant should not be regarded simply as the passive recipient of welfare. Although operating within such 'institutionally-defined constraints', some applicants at least do have the opportunity to exercise choice and to some extent, therefore, have a role to play in determining their own housing outcomes (Clapham & Kintrea 1986; English 1987; Henderson & Karn 1984; Jeffers & Hoggart 1996). In particular, social housing applicants are usually invited to express their preferences for particular types of home or specific locations and provided with the opportunity to reject offers they consider unacceptable.

The tenants' and applicants' survey shows that some households with medical priority actively seek to secure for themselves the most suitable or desirable offer of rehousing possible. Almost 90% (718/836) of those households surveyed in three local authorities said that they had placed restrictions on the kinds of offers they would accept. The most common request – from nearly half (387/836) of all applicants – was for ground floor accommodation. A quarter (208/836) specified a house, while more than one in ten (100/836) wanted a garden. More than a quarter (244/836) of applicants requested that they be rehoused within their own neighbourhood. There is evidence to suggest, moreover, that those specifying such preferences are more likely than those who do not, to secure them in practice. For instance, 79% (66/84) of those rehoused applicants who had requested a house were allocated one, compared with only 11% (28/265) of those who didn't. 47% (32/68) of those expressing a preference for a bungalow and 87% (88/101) who wanted to move to a flat, had their requests met compared with 6% (16/281) and 47% (117/248) respectively of those who did not. It is not known how many of all those rehoused moved to ground floor accommodation, but 90% (187/208) who made such a request, did so.

Allocations officers in the case study authorities emphasise their efforts to make acceptable offers to all applicants, including those with medical priority. While this might reflect their altruistic desire to satisfy as many people as possible, it is also

closely linked with their professional task of minimising refusals of offers. It clearly makes more sense to allocate the best dwellings, or those dwellings specifically requested, to 'choosy' applicants since the 'less choosy' are, on the whole, more likely to accept the poorer offers. Other studies of housing allocation systems have shown that the 'quality of demand' (Clapham & Kintrea 1986) or the expression of such preferences is not necessarily related to need (though perhaps here in the case of ground floor accommodation it may be), but rather to a reluctance to move to a less desirable home than that already occupied, satisfaction with current home and thus, ability to wait. This, it is suggested, might also be linked to the propensity to reject offers of rehousing – an act that itself has also been shown to improve offers made and to secure moves to the most popular neighbourhoods in particular, again as allocators seek to minimise refusals.

It is for these reasons that people with medical priority as a group receive some of the best offers of accommodation. The high priority awarded to this group puts them in a strong position to be 'choosy' and the earlier finding that people applying for medical priority only wish to move because their home is unsuitable for their health needs but otherwise satisfactory suggests that they are likely to demand similarly high standards of the home they move into. Many authorities also allow those with medical needs a greater number of offers before losing their priority status than other housing applicants in the waiting list. In a third (42/117) of those local authorities surveyed, new applicants and/or transfer applicants with medical priority can receive an unlimited number of offers of accommodation. In less than a quarter (27/117) are they required to accept their first offer.

Despite the evidence to suggest that, in most authorities, medical priority applicants often receive the best offers of rehousing of any needs group, the tenants' and applicants' survey shows that a substantial proportion still feel it necessary to exercise their right to refuse offers of rehousing in order to secure an acceptable move. Of those applicants surveyed that had received at least one offer of rehousing (n=452), half (n=213) had turned it down. Of course it is possible that some applicants might have unrealistically high expectations of the housing system in general and medical priority in particular, but offers were most commonly turned down by those surveyed because the accommodation was unsuitable for the household's health needs – either because it was in poor condition or because it did not consist of ground floor accommodation as required. Nearly 30% (64/213) and 24% (52/213) of refusers, turned down offers on these grounds. Dissatisfaction with the location of the dwelling

was almost as important. 21% (44/213) and 18% (39/213) respectively thought that the neighbourhood was unsuitable or disreputable, and therefore unconducive to an improved quality of life.

These reasons for refusal suggest that, even for those occupying such a privileged position in the housing queues, accommodation shortages can mean that if all medical priority applicants passively accept what is offered, a reduced number might secure the favourable and satisfactory outcomes described earlier. Although there is no evidence to suggest that those who exercise their right to turn down unacceptable offers receive on average better quality dwellings, data from the tenants' and applicants' survey does show that if applicants wait they are more likely to secure the facilities that were lacking in previous offers. Roden (1995) in a further analysis of this data was also able to show that those who do not accept their first offer of rehousing secure a home in a less deprived part of the authority than those who do.

What all this means is that the most 'choosy' households among those with medical priority or those most willing and able to put pressure on the housing department in their bid to secure a suitable or desirable move, are perhaps more likely to secure them. Put another way, one example of the tertiary rationing strategies employed by housing providers in the allocation of an uneven housing stock to those with medical priority, is to exploit the fact that some applicants have lower expectations and/or are more desperate to move and thus to offer people the minimum they will accept.

6.5 Conclusion

This chapter has shown how the interaction of housing stock constraints with housing management priorities leads to the rationing of limited housing resources through the formal and informal prioritisation of individuals and groups with a range of housing needs relative to one another in the housing queues. The welfare ideal of meeting housing need is compromised and only a limited number of needs are met.

The effect of such prioritisation, however, is advantageous to people with health needs as a group in most – though not all – authorities. Thus people with medical priority secure a high position in the housing queues at the expense of other needs groups and are rehoused relatively quickly and in the most desirable housing. At the same time, however, these same rationing processes lead to the prioritisation of people with

medical priority relative to one another and this means that equal housing and health opportunities are not available to people in equal health need.

Chapters Five and Six have shown that although medical priority rehousing represents an effective health intervention for the majority of those people who are successful in securing a move through the system. They have also shown however that, due to resource shortages, medical priority is increasingly failing to cater for the majority of people in health need and sometimes for those in greatest health need. In this light, Chapter Eight discusses how the medical priority system itself might be improved in order to increase its effectiveness. Chapter Seven, on the other hand, will now consider the housing opportunities provided for people with health needs in other parts of the housing system.

7

HEALTH AND THE HOUSING MARKET

7.1 Introduction

The burden of providing healthy housing and of administering housing for health strategies has, as we saw in Chapter One, traditionally fallen to the social rented housing sector, and to council renting in particular. This public health role, which, in recent decades has been exercised through the award of medical priority in the housing queues, has been possible because housing in this sector is allocated according to some measure of need. Medical need has traditionally been recognised as an important indicator of housing need and therefore a key factor in the dispensation of social housing resources. The last chapter confirmed that social housing interventions are associated with access to healthier homes, improved health, better access to care and improved quality of life. However the thesis also points to the limited capacity of a shrinking and restructured social rented sector to accommodate growing demand from people with health and mobility needs. This raises important questions about how this population group fare in the remaining – and the largest – part of the housing system, that of the market sector, where access is determined not by need but by ability to pay.

The decline of the social housing system and the associated reduction in opportunities for those with health needs in this sector was largely related to the ideological concern of successive Conservative governments with promoting the 'property-owning democracy' and, to a lesser extent, the private rental sector. The opportunity, indeed right, for large numbers of local authority and housing association tenants to purchase their homes at discount prices, increasing social sector rents and the reduced size and quality of the sector all served as incentives for social sector tenants to become home owners or private renters. Owner occupation was also actively promoted through the continued subsidisation of home owners through Mortgage Interest Tax Relief (though

after April 1995 this was reduced from 20% to 15% – and following the first Labour Budget now stands at 10%) and capital gains tax exemptions and especially through the deregulation of the financial sector in the mid-1980s. Together the Financial Service Act 1985 and the Building Societies Act 1986 had the effect of making access to mortgage facilities easier as the range of lenders increased and loans were more readily available (Forrest & Murie 1994). A number of initiatives to stimulate the private rental sector – including the deregulation of rents and lettings and the provision of tax incentives to those investing in the sector (Crook & Kemp 1996) – were also introduced.

The result is that there are now nearly 4 million more home owners in England than there were in 1979 (DoE 1995) and that 68% of households currently own, or are in the process of buying, their own home, compared with 56% in 1979. The private rented sector still only accounts for about 10% of households, though this represents a reversal of the decline that has characterised the sector for more than fifty years (Crook & Kemp 1996). On the other hand, while 31% of households in 1979 rented their home from a social landlord, now just 22% do so.

This growth in home ownership is associated with its extension 'downmarket'. More people on low incomes are now owner occupiers than ever before. Today half of all first time buyers have incomes of £17,000 a year or less before tax and a quarter have incomes of £12,000 or less (DoE 1995).

Of interest here, the evidence also suggests that more people with health, mobility and care needs are currently home owners than has previously been the case. Increased opportunities to enter the sector over the past two decades, together with the rising number of people entering their retirement years as home owners means that today over half of all disabled adults and around two-thirds of those aged over 65 currently live in owner occupied housing (Martin & White 1988; OPCS 1996). It also seems likely that the reduced social renting opportunities for those who cannot or do not wish to access owner occupation might also have led to an increasing number of people with health needs entering the private rental system (Smith 1989).

Notwithstanding increased opportunities in, or pressures to enter, the market sector of the housing system since 1979, an important point is that access to this sector is determined solely by ability to pay and not need, medical or any other. The sole aim of the housing market is to secure profit. It therefore caters for need only when this can

be paid for and is profitable. This chapter will explore the implication of this by considering the interaction of health status and housing market opportunities. It will be concerned with the issue of accessibility of owner occupation and private renting to sick people and the extent to which private sector housing interventions might meet health needs. The Conservatives argued that their housing policies were 'entirely consistent' with public health aims. Certainly the extension of home ownership was meant to be about giving people more choice with regard to health and other benefits, and about affording people an appreciating asset that in later life would help maintain their living standards (Secretary of State for Health 1992; DoE 1995). The extent to which this is true, however, remains unexplored.

Almost a decade ago Smith (1989, p. 6) warned that '.... we know almost nothing about how an enlarged owner occupier market or a revitalised private rental sector will cater to those suffering from intermittent or enduring ill-health'. This question continues to represent an important gap in the housing research agenda (Easterlow *et al.* 1998). As such the chapter necessarily draws largely on the wider housing literature and attempts to relate this to the opportunities of this particular population group. It does however draw upon the limited information available from a (previously unanalysed and unpublished) pilot study of the housing problems faced by people with health, mobility and care needs carried out in Edinburgh in 1990 by the English Medical Priority group of researchers (see Appendix I).

7.2 Health and access to the private housing system

Smith (1991) highlights two reasons why we might expect those with health needs to be disadvantaged in that part of the housing system run along market lines. Firstly, this population group is disproportionately poor (Martin & White 1988; Rowlingson & Berthoud 1996). Ill-health is an important determinant of earning power. Chronic sickness or disability may exclude some people from employment altogether. For others their health problems may place them at a disadvantage in the new flexible labour market, by restricting them to the 'casualised periphery' where incomes are low and not guaranteed and sick pay benefits are limited or non-existent. Moreover, the disposable income of these groups may be depressed still further by the increased living expenses associated with ill-health. Sick, vulnerable and disabled people, particularly those who are confined to the home, may face extra expenditure on heating bills, care provision (particularly since the introduction of charging by local authorities

for day and domicillary care services) and special facilities for the home (Baldwin & Lunt 1996; Chetwynd *et al.* 1996; Martin & White 1988; Smith 1991; Thompson 1990). Thus, notwithstanding wide geographical variations in housing costs (house prices and private rents), when access to and continued participation in the housing market depends on ability to pay, sick people may not find owner occupation in particular a widely available option (albeit more so in some areas than others).

Secondly, in the pursuit of maximum profit, the housing market tends to concentrate on providing the type of accommodation in greatest demand. It does not tend to supply the type of housing with the aids, adaptations and facilities required by some of those households with health needs (Morris 1991; Rolfe *et al.* 1993; Smith 1991). For instance, the English House Condition Survey (DoE 1993) found that only a quarter of private sector dwellings are accessible to disabled people compared with a third of local authority and housing association dwellings.

A lack of suitable accommodation and/or anticipation of unaffordability might persuade some people not to enter the private housing system. Others may be thwarted in their attempts to gain access through their failure to secure mortgage finance, or inability to cover rent costs. At a time when access to mortgage finance increasingly depends on the availability of two dependable and regular household incomes, those households where at least one adult member has significant health problems may be considered too much of a risk by mortgage lenders, particularly when they must increasingly rely on the insurance industry rather than the state to guarantee payments, if not by themselves. It is for these reasons that some people with health needs do not gain access to either owner occupation or private renting.

7.2.1 Sustaining owner occupation

As we saw earlier, however, people with health needs do gain access to the private housing system and indeed increasing numbers of such households are currently home owners or private renters. Having entered owner occupation or private rental, either in poor or good health, there are a number of reasons why a position in the market sector of the housing system might be unsuitable and unsustainable for many of those with health, mobility and care needs in the longer term. Figure 7.1 illustrates how sickness and disability can interact with housing affordability in the owner occupied sector. Some of these issues are are picked up again in Section 7.3.

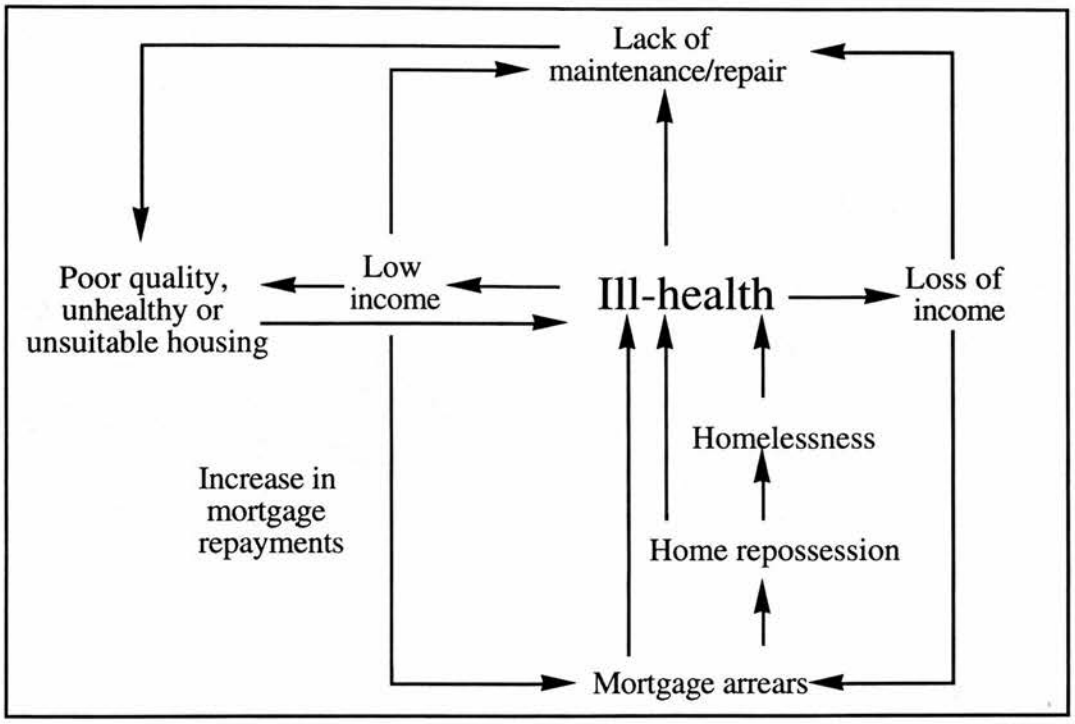

Figure 7.1 Ill-health and home ownership

The events of the late 1980s and early 1990s when record numbers of households found themselves in mortgage arrears and losing possession of their homes, illustrated well the risks of home ownership for wide sections of the population, including, perhaps in particular, those with health problems. Arrears peaked in 1993 when more than 510,000 households in the UK owed three or more months payments. Repossessions also rose – to a high of 75, 540 in 1991 (Wilcox 1996). Although both the numbers experiencing arrears and repossession have been declining in recent years, they nonetheless remain at high levels – over 85,000 households were more than twelve months in arrears and over 49,000 households had their homes repossessed in 1995 – and serve as an important reminder of the precarious financial positions large numbers of home owners continue to find themselves in, particularly those on low incomes.

The pronounced shift from mortgage rationing towards lending on demand that followed the deregulation of the mortgage finance sector (Forrest & Murie 1994), while increasing access to home ownership for many low income groups, has also, it follows, increased the number of people who have high levels of mortgage debt

relative to their disposable income, particularly in the south of the country where house prices are highest. This group is most vulnerable to any increases in their mortgage repayments. Even small increases in housing purchase costs can result in financial difficulty. The rise in interest rates during the latter half of the 1980s – building society interest rates on new mortgages rose to an all-time high of 15.4% in February 1990 – was one of the factors associated with the increase in mortgage arrears at this time. Loans designed to assist lower income groups, who we might expect to include those with existing health problems, and those without a deposit gain entry into owner occupation were then and continue today to be those most likely to lead to arrears (Forrest & Murie 1994).

Those with high mortgage debt relative to income (including, though not solely those on low incomes) are of course not only vulnerable in the event of rising mortgage costs, but of a drop in household income. Ford *et al.* (1995) in a survey of almost 500 households in England either in mortgage arrears or having experienced possession of their home, found that redundancy and a drop in earnings were the two most important factors leading to mortgage difficulties. Clearly these events could both be related to a change in health status. The deterioration of existing health problems, or for those borrowers entering owner occupation in good health, the onset of illness or disability, can lead to the need to change jobs, reduce working hours and even to job loss. Indeed in the same survey, 13% of respondents gave the onset of illness, disability or accident as one reason for getting behind with their mortgage payments. A similar proportion said that it contributed to the repossession of their home.

One woman interviewed explained how the onset of ill-health in both her husband and herself led to problems in meeting mortgage payments:

> *At first the decline in the building trade – my husband is in sub-contracting as a self-employed ceiling fixer – made the regular full payment difficult. We took out a second mortgage but then it got worse. My husband became ill and had to have an operation and couldn't work at all. Because he only paid a self-employed stamp he couldn't get unemployment (benefit) or much help. Then I also became ill and had to have an operation - after changing to full-time work in an effort to pay the mortgage. Now I can't return to work.*

Illness in other family members, if this means that a borrower must leave formal employment to take up an unpaid caring role, was also found to be problematic:

> *My wages dropped when the firm was taken over. They stopped the commission and Karen had to give up part-time work to look after her*

mum. Our income went down by £150 per week.

The onset of ill-health in any family member whose wage is required to sustain mortgage repayments may also lead to other earners having to give up their jobs to fulfil a caring role. A number of households included in the Edinburgh study had no wage earner in the family for this reason.

Not only, it seems, can health needs make owner occupation a risky housing tenure, but there is evidence to suggest that the experience of mortgage arrears can itself be harmful to health and detrimental to well-being. (Nettleton 1998; Nettleton & Burrows in press). Burrows (1998, p. 6) has argued that 'the experience of mortgage arrears is such a stressful life event and is now so common that it could usefully be reconceptualised as a major public health issue'. In an analysis of the British Household Panel Survey, Nettleton & Burrows (in press) found that mortgage problems were associated with higher levels of depression and anxiety among both men and women and with an increased use of GPs. They argue further that the increased prevalence of mortgage difficulties and home possessions since the mid-1980s may not just affect those experiencing them, but might generate a sense of unease and anxiety among the wider home-owning population, who if not facing problems themselves, fear they might in the future.

The anxiety associated with mortgage indebtedness and repossession might, in part, be related to the fear of homelessness, and indeed for some this will become a reality. In the past, borrowers experiencing financial problems were more usually able to sell their property and trade down, or move into the social rented sector. The depressed housing market of the early 1990s and a reduced social sector shows how the availability of these options should no longer be taken for granted. In 1991 when mortgage repossessions were at their highest, local authorities rehoused no more than 40% of compulsory repossessions and approximately a quarter of all repossessions (Joseph Rowntree Foundation 1994). Furthermore, those who sell their home, leaving themselves without accommodation, to clear their debts are regarded as 'intentionally' homeless and often excluded from the local authority and housing association waiting lists. The harmful health effects of losing one's home in such a way may be compounded by the exposure to poor living conditions, whether in the homes of friends or relatives, temporary hostels or B&Bs or even on the streets. The experience of homelessness may exacerbate existing physical and mental health problems (perhaps the cause of mortgage problems in the first place) and may even be the source

of new ones. The distinctive health profile of homeless people (see Shanks & Smith 1992, Bines 1994 and Robinson 1998 for excellent reviews of the evidence showing a greater incidence of a range of physical and mental health problems amongst the homeless), may not only warn as a strict reminder of the health implications of becoming homeless, but might represent direct evidence of the selective effect of ill-health in the private housing system at a time when opportunities in the social sector are limited (Connelly & Crown 1994; Morris 1991; Robinson 1996; SCOPH 1994; Shanks & Smith 1992; Smith 1990a). In a 'census' of homeless people including residents of all hostels, day centres, reception centres and cheap temporary bed and breakfast accommodation, as well as all those who could be found living on the streets, in Sheffield in 1988, Shanks and Smith (1992) found that fully 11% were made homeless through illness.

7.2.2 The mortgage safety net

While Conservative governments during the 1980s and 1990s were committed to extending the opportunity to own a dwelling to larger sections of the population, they were not concerned to reduce the 'riskiness' of this tenure. Indeed the risk associated with home ownership may have been increased recently as the state welfare system in place in this part of the housing system – the Income Support Mortgage Interest payments scheme (ISMI) – was treated to a dose of the same Conservative restructuring ambitions experienced earlier by other housing sectors (Ford & Kempson 1997).

A state safety net for mortgagors who lose all income as a result of unemployment, sickness or accident has been in place since 1948 (Ford & Kempson 1997). It is one that remained relatively unchanged until 1987 when restrictions on the amount payable to eligible households were introduced by the Conservatives. These restrictions have certainly compounded the problems faced by some households later in that decade. However, in October 1995 further, more substantial, restrictions in government assistance were introduced that might make home ownership an increasingly hazardous tenure in the late 1990s, particularly for those with health problems. From October 1995, borrowers taking out mortgages after that date and accepted as Income Support claimants, would receive no support for the first 39 weeks of a claim and full eligible interest thereafter. Those whose loan had been taken out prior to that date would receive no support for 8 weeks, followed by up to 50% of their eligible interest

for the next 18 weeks and full eligible interest thereafter. (People over 60 years of age are exempt from these restrictions and easements are available for other groups such as those who leave employment to care for relatives.)

Arguing that the income support arrangements up to that point had effectively provided support for the lending industry, and that 'it is reasonable to expect people entering into the long term financial commitments entailed by home ownership to take personal responsibility and make provision for short time difficulty', the Government were concerned to shift the responsibility 'back to where it belongs – with borrowers, lenders and the insurance industry' (DoE 1995, p.16). Reducing state assistance, it was argued, would lead to more prudent borrowing and lending behaviour and would encourage the development of a more comprehensive insurance market. Together, it was argued, this would lead to greater overall protection for those who fall into difficulties.

At the time of these changes, the private mortgage protection insurance market was not well developed. Take-up of mortgage protection policies, most commonly the ASU cover (combined accident, sickness and involuntary unemployment) was relatively low – only 12 or 13% of all mortgagors had such cover (Ford *et al.* 1995), existing policies were not available to all borrowers and cover to those with policies was often limited. In particular, self-employed borrowers, those on short-term contracts and, of interest here, people with certain health problems were regularly excluded. Borrowers who were eligible often faced problems over the waiting period before payments were made, as well as uncertainties in how long they were made for. Since then there has been an increase in the range of insurance policies available, with many of them offering more comprehensive cover than was previously the case. The number of borrowers taking out such policies has also risen.

A recent study by Ford and Kempson (1997) found, however, that the process of widening the cover provided by private mortgage protection policies may have been accompanied by an increase or tightening up of criteria that borrowers must first satisfy. Their findings suggest further that people with health needs may continue to face difficulties in securing cover. For instance they found that although those with unstable employment histories face the most restrictions, among the 19 ASU policies they considered, four excluded completely those with a pre-existing health problem, and a further fourteen imposed special conditions on this group. This usually meant having received no treatment for the previous twelve months. Some types of illness

and disability were excluded completely. Moreover, while they found evidence of the increasing relaxation of conditions of eligibility overall, pre-existing medical conditions such as stress and backache were being added to the list either as eligibility criteria or as conditions that would not qualify for a claim. Take-up of private mortgage protection insurance by sick and disabled people is therefore unsurprisingly below average (Ford & Kempson 1997).

Furthermore, for those households who are eligible for cover, although the cost may have declined since the beginning of the decade, at between £3.85 and £6.45 per £100 benefit (Ford & Kempson 1997), and according to Burchardt and Hills (1997) at higher level than necessary, this can add, on average, a further 5 to 6% to existing mortgage costs (Wilcox 1996). For those who can already barely meet their mortgage payments – those who are most in need of cover should they suffer a drop in income, whether this be through ill-health, unemployment or accident, private insurance – this will not be a widely available option. Indeed estimates suggest that even today between just 1 in 5 and 1 in 6 borrowers now hold such cover (Ford & Kempson 1997).

Despite this, if a household is not covered, adequately or at all, by the state safety net or by private insurance, assistance from other sources to prevent possession of the home in the event of mortgage difficulties, is extremely limited. At the height of the housing crisis earlier this decade, building societies and housing associations were encouraged by the government to set up mortgage rescue schemes. But these were by voluntary agreement and they have never represented an adequate solution to the problem of home repossession. Such initiatives include concessionary payment agreements between lenders and borrowers. These enable borrowers to pay less than the normal payment for a period of time until a more permanent solution is discovered (Bramley 1994). Although there is evidence that contact between lenders and borrowers do appear to have increased as a result, one study of households in mortgage arrears found that only 30% had come to an agreement about payment (Joseph Rowntree Foundation 1994). Other mortgage rescue schemes include converting owners to tenants and shared-ownership initiatives. The concept of shared ownership was developed in the 1980s initially as a means of helping people to get a foot on the home ownership ladder, by allowing them to purchase part of a property and pay rent to a housing association on the rest (Bramley & Dunmore 1996). By the early 1990s such schemes were being employed in a bid to prevent people falling off that ladder and losing their homes at the same time. This involved the acquisition of

properties by housing associations, using a loan from the lender to finance the purchase, with the occupiers remaining as tenants or shared owners and becoming eligible for housing benefit (Bramley 1994). Some local authorities were also involved in establishing their own mortgage rescue plans along the same lines. Although such schemes are envisaged by the current government as potentially playing an important role in the reduction of repossessions, they have proved to be unpopular among borrowers. Owner occupiers, even when facing financial difficulties, are, it seems, reluctant to relinquish even part of their rights of ownership. Moreover, the massive increase in funds to local authorities and housing associations that such a role would require do not appear to be forthcoming.

Since there is no evidence to suggest that the current government has any plans to reverse the cuts to the state mortgage safety-net made by its Conservative predecessor, this discussion raises some important questions concerning the most appropriate balance between state and private welfare provision to home owners if owner occupation is to be a sustainable tenure for 'risky', needy groups such as those with health problems, who are more likely to face difficulties. The current balance places many such borrowers in an increasingly marginal and vulnerable position within the sector at the same time as their access to social renting has been reduced.

7.2.3 Access to private renting

For those households who do not wish to enter owner occupation or find it an unaffordable tenure, there is a further housing option within the private sector, that of renting from a private landlord. Indeed Conservative housing policies sought to promote private renting as the most important rental tenure and the most significant alternative to home ownership. Despite their attempts to revive the sector, however, private renting has not grown as fast as expected (Crook & Kemp 1996). Furthermore, the current government retains only a limited commitment to the private rented sector, seeing local authorities as the most important landlords. Nevertheless, one in ten households currently rent from a private landlord and the opportunities for those with health needs in this tenure are worth exploring briefly here.

As part of the private housing system, access to this sector similarly depends on ability to pay. Although a more comprehensive system of state assistance with housing costs exists for private renters through the housing benefit system than does for owner

occupiers (Kemp 1994), there are a number of reasons to suggest that this may also be a precarious tenure to enter and reside in for some people with health needs.
An important point is that the Conservative governments did not seek to revive the sector by making it more attractive to potential renters (although the residualisation of local authority sector, might, it was realised, serve to encourage people to rent privately), but by increasing the incentives for landlords to invest. Thus the effects of the Housing Acts 1980 and 1988 were to deregulate rents and lettings. This involved the move from regulated tenancies to assured and assured shorthold tenancies (Kemp 1993). This led to rising rents as landlords began to let at market prices – private market rents in England currently stand at almost twice average local authority rents (Wilcox 1996) – and reduced security of tenure for tenants as simplified and extended grounds for landlords seeking to repossess their property were introduced (Crook & Kemp 1996).

Thus reasonable and regular incomes are increasingly required for entrance to, and a position in, this sector and this excluded many sick people. Although the housing benefit system is in place to offset rent costs for those on low incomes, it has been subject to a series of cutbacks since 1980 reducing eligibility (Kemp 1994). Since 1989 local authorities have also been obliged to refer new claims on deregulated tenancies to the Rent Officer to determine whether the rent is above a 'reasonable market rent', in which case only a proportion of the rent is eligible. Since October 1995, moreover, further housing benefit restrictions in eligible rents have been in place. Where tenants live in accommodation with rent levels above the mid-point in the range of rents for the locality, the local authority is not liable to pay housing benefit on all that rent. Similarly, while in the past councils were obliged to meet even those rents above the reasonable market rent assessed by the Rent Officer, if the claimant fell into a 'protected' group – including people with certain health needs and other community care groups – this protection was removed in 1995 and replaced by a small, cash-limited discretionary budget.

It has therefore been argued that these restrictions together with the backlogs and delays in processing housing benefit claims, can lead to high levels of stress and anxiety among tenants, particularly among those who are already sick or vulnerable such as older people and those with mental health needs (Joseph Rowntree Foundation 1995d, 1995e). Fears that the rent may rise and become ineligible for benefit lead to worries about having to move home – itself a stressful process – or meeting the increased costs somehow.

What all this means is that the effects of Conservative housing policy in the 1980s may have made this a more inaccessible, precarious and unsuitable housing sector for people with health needs in the 1990s.

7.3 Housing conditions, health needs and the housing market

7.3.1 Access to 'healthy' homes

Once a position in the owner occupier or private rented housing sectors is achieved, an important question surrounds the extent to which this represents a healthy housing service for those with particular kinds of health and mobility needs. There are in fact a number of reasons why we might expect this population group to attain accommodation that is unsuited to their needs. Figure 7.1 shows the various routes into 'unhealthy' private sector accommodation in the largest of these sectors, that of owner occupation, that people with health needs might follow.

Firstly, since, as was highlighted earlier, the market does not routinely provide the housing designs and facilities this group often require, what this means is that some people will be forced to buy or rent homes that are not suited to their health needs. In particular, there appears to be a shortage of affordable, ground floor accommodation for those with walking difficulties. Many of those interviewed in Edinburgh complained of this. Similarly, for those who enter the housing market in good health but become sick or disabled and for those whose existing health problems deteriorate or are joined by new ones, the home that was previously adequate for the household's needs, may become unsuitable for the new ones.

Secondly, the private housing system – just like the social sector – includes dwellings of widely varying quality. The 1991 English House Condition Survey (DoE 1993) found that although the 'healthiest' tenure overall, 715,000 or 5.5% of owner occupied homes were unfit for human habitation. Over one-fifth of private rental homes were found to be unfit. This compares with 6.9% of local authority and 6.7% of housing association homes. Similarly, the worst housing conditions are found disproportionately in the private rented sector. Almost a third of private renting households live in the poorest 10% of dwellings in England. Fewer than 10% of households in the other sectors live in this housing. Reflecting the greater size of the owner occupier sector, however, over half of these 1.3 million unfit dwellings are

found in this sector. Thus, as Littlewood and Munro (1996, p. 503) point out, 'there are now a considerable number of owner occupier households living in physically poor housing conditions, with consequences for their health and well-being'.

The survey also found that within the private sector – though not the social sector – income is an important determinant of housing conditions. Older people – the largest single community care group – and particularly those living alone are over-represented amongst those living in the worst condition owner occupier and private rental housing. There is good reason to suspect that others with health needs will be disproportionately found here too.

Thus a third route to 'unhealthy' housing for those with health needs might be the result of a process whereby health status interacts with access to different parts of the housing stock. For those entering owner occupation or private renting in a poor state of health, it would not seem unreasonable, as Smith (1989) argues, to assume that a significant proportion will gain access only to the worst parts of the housing stock. The 1991 English Housing Condition Survey confirmed that disrepair and poor housing conditions are concentrated in the cheapest part of the housing stock. This accommodation can, of course, exacerbate existing health problems and/or contribute to the onset of new ones. It is this same process, moreover, that can lead to low income, but healthy, households being exposed to poor living conditions and becoming ill.

Fourthly, house conditions deteriorate over time unless the property is regularly maintained. If repair and improvement work are not carried out, the dwelling that once provided a healthy living space may become an unhealthy one.

In the local authority and housing association sectors, repairs, maintenance (and sometimes) the adaptation of the dwelling is the responsibility of the landlord. The financial burden does not therefore fall directly on tenants. In the private rental sector the responsibility to keep the property in good condition is also the landlord's. A survey of older private renters by Rolfe *et al.* (1993) found however that landlords in this sector were almost universally unwilling to carry out repairs or adaptations unless this was at no cost to themselves, and that many tenants were reluctant to approach him or her for fear of 'causing trouble'.

For owner occupiers the maintenance, improvement and/or adaptation of the home is their own responsibility. Munro *et al.* (1994), in an analysis of the 1991 Scottish House Condition Survey, found that the long term sick and disabled were one of the groups of owner occupiers most likely to have done (or had done) work of either a repair or improvement nature to their homes in the twelve months prior to the survey. From what has gone before, this may reflect the limited access of this group to good quality owner occupier housing, but it might also relate to their greater need for their home to provide a healthy living space, particularly if they are house-bound. Notwithstanding this finding, the Edinburgh study suggests that people with health problems may face a number of difficulties in maintaining their homes.

The 1991 English House Condition Survey (DoE 1993) found that although the average cost of general repairs required in the owner occupier sector was 85% less than in the private rented sector, at £1,940 it was still significantly higher than for those tenants whose local authority (£820) and housing association (£710) landlords were responsible. For those borrowers whose health needs depress their income so that the household budget is already tight, if they manage to meet their mortgage payments they might not be in a position to cover the costs of the upkeep or adaptation of their home, which progressively becomes more unhealthy and unsuitable. One married couple in Edinburgh were asked if the husband's ill-health which had forced him to retire from employment and his wife to undertake part-time work only in order to care for him, had led to difficulties with meeting their housing costs. They replied:

> *Not with the mortgage. It's just with this house we have had a couple of problems with rising damp at the beginning of the year and water coming [in] from the people above.... These kinds of things are a problem.*

It is for the same reason that we might expect those who moved to poor housing to not be in a position to rectify these problems. For those healthy home owners who had, in the past, been able to keep up with the maintenance of their home, the onset of ill-health resulting in a decline in income, may prevent this in the future. The problem of disrepair in the owner occupied sector is expected to become more severe as increasing proportions are drawn from lower-income groups who have limited resources with which to finance repair works (Littlewood & Munro 1996).

The financial cost of such work is, moreover, an expenditure which people with health problems may not be able to avoid by undertaking the work themselves (Smith 1991).

One owner occupier with Multiple Sclerosis in Edinburgh told how his illness prevented him from carrying out any improvement or maintenance work in his home:

> *The other thing is [that] everything which is done around the house, whether it is painting (we've just had the outside painted), gardening, putting up shelves, every single thing that is done in this house I have to pay for. It is an expensive business being disabled.*

For many people, ill-health is associated with ageing. For this group of people with health needs, early participation in owner occupation and long-term maintenance of the home can, once the mortgage has been paid off, as argued by the previous government, ensure a low cost 'healthy' home (and an asset that can be employed to maintain living standards and pay for medical and social care – see later). However the English House Condition Survey found that older households, particularly lone older owner occupiers, are disproportionately represented in the worst condition housing (though they were found to occupy the best social sector housing). While this is undoubtedly related to the fact that they are more likely to occupy the oldest parts of the housing stock where maintenance costs are highest, and because older home owners are argued to find the disruption associated with repair work especially distressing, those older home owners living in the worst stock were also found in the lowest income bands. Such problems were recognised by an older owner occupier interviewed in Edinburgh. She had recently experienced problems with a leaking roof and difficulties in getting it fixed properly. She told how she had decided to move to a housing association dwelling in order to escape the responsibility for such repairs which were costly, and which she found stressful to organise:

> *I find that I have been a house owner since 1957 or 58 and I really feel [that] I want somebody else to take over the burden.*

In such situations the scope for moving home to better quality, more suitable accommodation may be limited. This housing is likely to be more expensive if it exists at all. In Edinburgh, one woman interviewed suffered from Multiple Sclerosis and complained that as the disease had progressed the steps in her house had become difficult to climb. When asked if she would have to move home, she replied:

> *Oh definitely....[but].... not in the near future. Financially I just can't see it. Apart from anything else, when I became disabled, a two-income family became a one-income family.*

Moreover, looking for a more suitable home and moving to it can be particularly difficult to organise and carry out for those whose ill-health means they are housebound. When asked if she was planning to move from the house whose stairs had become unsuitable for her walking difficulties, a second Edinburgh respondent replied:

> *Well, I wouldn't be able to. I can't go looking around and doing all the things involved in moving house.*

Of course, moving home can itself be a stressful process, detrimental to health.

What all this means is that those people with health needs who do manage to access the private housing system and sustain their position within it, may face difficulties in securing a home that is suited to their needs and in ensuring that the home remains suitable.

7.3.2 Home improvement grants

Financial assistance from the state for the repair of private sector dwellings has been available since 1969. Since 1974 when the current local authority home improvement grant system came into operation, grants for disabled people to obtain accessible basic amenities and carry out adaptations to their homes have also been provided. The contribution of the grant system to ensuring decent housing and good health and to community care aims was recognised by the last government. Local authorities were urged to employ their finances to tackle housing problems such as cold and damp which can have a particularly damaging effect on health and to improve the housing conditions of vulnerable people, including sick, disabled and older people to help them to continue living independently in their own homes (DoE 1995).

This assistance, however, represents a further area of housing welfare to have been radically restructured by Conservative governments. The home improvement grant system was substantially altered by the 1989 Local Government and Housing Act, and again by the Housing Grants, Construction and Regeneration Act 1996.

The main features of the 1989 Act were the introduction of 100% grants and of financial means-testing to establish eligibility for assistance. This, it was believed, would allow for the greater targeting of resources to those on low incomes. Most

people can and should maintain their own homes it was argued. The Act also introduced two major new grants – the renovation grant and the disabled facilities grant (DFG) – which were available as of right for applicants who met the eligibility criteria. The renovation grant is available for work to bring properties up to a new standard of fitness for human habitation as set out in the Act. It is available to owners of private housing (including private landlords) whose properties are in serious disrepair, structurally unstable, or lacking basic amenities such as cooking or bathing facilities (Mackintosh & Leather 1993). The disabled facilities grant – the first grant available specifically for adaptation work – is available for adaptation work covering adaptations to provide access into and around dwellings, to make it possible for a person with a disability to reach and use essential amenities and to provide facilities to enable people with disabilities to live independently in their own homes (Heywood 1994; Mackintosh & Leather 1994). The grant is available to people in all housing sectors.

Although government expenditure (provided through local housing authorities) on housing grants rose in the first half of the 1980s, this was followed by cuts in spending in the latter half of the decade, and the level of resources has remained restricted since the introduction of the new grant system in 1990. Total grant budgets fell from £684 million to £378 million between 1985 and 1994 (Heywood 1996). The amount of money devoted to this type of housing subsidy is therefore relatively small. Indeed grant aided renovation represents approximately just 1% of total expenditure on the repair and improvement of owner occupied homes for instance (DoE 1995).

In addition, the availability of grant assistance has declined as the total number of grants provided by housing authorities has fallen. At the same time as funding has remained restricted, average grant sizes have increased since 1990 as more households receive 100% grants than previously (though in 1994 the government introduced a new lower maximum limit of £20,000 compared to the previous maximum grant payable of £50,000). In England, provision stands at around 60,000 per annum in the mid 1990s compared with around 150,000 in the mid 1980s (DoE 1997b). As a result, many local authorities struggle to meet the increasing demand for mandatory grants, both renovation and DFGs throughout the 1990s.

What all this means in practice is that resources are being heavily concentrated on a relatively small number of households, albeit those on low incomes, and no financial help is available for the majority of households who need it. Waiting lists for grant

assistance from local housing authorities are now a common feature of many districts and as a consequence the grant system is often not publicised for fear of attracting further demand (Mackintosh & Leather 1994). Moreover, although the system of means-testing was intended to direct resources to those most in need, and has to some extent been effective in doing so, its introduction appears to have led to an increase in the drop-out rate as people are deterred by the complexity of the process, by having to reveal their finances, and/or by the amount they discover they must contribute. A number of the case study authorities included in the national study employed in this thesis commented on the dramatic overnight increase in the number of people dropping out from DFG applications in particular. The means test has been criticised for its unfair treatment of some households (Morris 1991). It considers the incomes and savings of all people with an interest in the property as joint owner or joint tenant and who live in the property, for instance, but takes no account of mortgage or other outgoings (Heywood 1994). As such, the contributions some households with low disposable incomes are expected to make, are unrealistic. The system therefore works best for retired people on low incomes with no mortgage.

Another important point is that the availability of grant resources varies markedly between local authorities – and not necessarily according to level of need. Leather and Mackintosh (1993b) argue that capital allocation procedures have long not directed significant resources to the local authorities with the worst problems of poor private housing conditions. As a result, many of the larger urban authorities have been unable to spend as much on renovation grants as the scale of their problem would suggest. Although unable to relate this to levels of need, Heywood (1994) found that in the early 1990s the number of DFGs awarded varied by more than 500 times, and while the average grant in England in 1992-3 was £3,536, in some areas it was as high as £17,300 and as low as £665 in others.

This uneven availability of grant resources will, moreover, be compounded by the Conservative Housing Grants, Construction and Regeneration Act 1996. The purpose of this Act is not to increase funding to those areas most in need, but to give local authorities more control over the limited resources they have by making the award of the renovation grant – though not the disabled facilities grant – discretionary.

Funding and provision of adaptations for privately-owned properties is also available from social services departments and health authorities. Part II of the 1970 Chronically Sick and Disabled Persons Act laid a specific duty on social services departments to

see that home adaptation needs are met. Today they are usually responsible for providing grants for minor adaptations and top-up finance for local authority disabled facilities grants where the grant does not cover the full costs of the work. In 1994, in the UK as a whole, social services departments funded adaptations to the extent of 75% of that of housing authorities (Heywood 1996). Health authorities may also provide equipment on a temporary basis for those leaving hospital (Mackintosh & Leather 1994). Since the introduction of the disabled facilities grant, many social services departments have, however, reduced their adaptations budgets, some to almost nothing, in the mistaken belief that sufficient resources are available from housing authorities. As a result there are now serious problems of underfunding for both minor adaptations and top-up for DFG in many areas (Heywood 1994; Mackintosh & Leather 1994). Thus, like housing authority grants departments, most social services departments do not publicise their own services for fear of increasing demand (Heywood 1994; Mackintosh & Leather 1994).

Prior to the last election, the Labour Party acknowledged the problems that many home owners face in sustaining their position in the owner occupier sector and in maintaining their homes. It argued for a 'collective responsibility' towards ensuring that nobody should have to live in substandard housing. One means of ensuring this in the short term, it was recognised, would be to raise the 'home improvement premium' in the means test, to allow more people on modest incomes to be considered for appropriate levels of grant. In the longer term, it was argued, a complete review of the whole system is required. It is clear that, at the present time, however, the ability of local authorities to provide more grants and to employ this housing service effectively in the project of housing for health is limited by the shortage of resources.

7.3.3 Home improvement initiatives

In a context where the responsibility for the maintenance and improvement of private sector dwellings has shifted further from the state to the individual owner (mirroring that shift in responsibility for housing costs), the importance of initiatives that make most efficient use of existing grant aid or of a household's own wealth in helping households to repair maintain and adapt their homes has been highlighted both by the last and current governments. Their contribution to the promotion of public health and in furthering community care aims by enabling people to stay put in their own homes, has also similarly been emphasised.

Those initiatives most commonly referred to include the service provided to home owners (and to a lesser extent private renters and landlords) by home improvement agencies (HIAs) and equity release/shared ownership schemes. These will be considered next with particular consideration of their current and potential effectiveness in meeting the (private) housing needs of people with health problems.

7.3.3.1 Home improvement agencies (HIAs)

Home improvement agencies are organisations whose aim is to provide practical help to households seeking to carry out repair or adaptation works to their homes in order to enable them to 'stay put' in these homes. The help provided includes technical advice on building problems, financial and welfare rights advice, assistance in obtaining or arranging finance for building work, help with finding builders and with the supervision of work (Leather & Mackintosh 1992). HIAs have mainly confined their service to owner occupiers, though some schemes also provide help and advice to private tenants. Among owner occupiers, older people have tended to be the priority group, though more recently the service has increasingly been extended to disabled people and others on low incomes living in poor housing conditions. On average, over half of all clients of HIAs have a health problem or disability (Heywood 1994). In some cases, agencies help clients not just to improve the physical fabric of their home but to secure care and social support in their homes by liasing with health authorities, social services departments and voluntary sector organisations (Harrison & Means 1990).

HIAs have been established and/or funded by a wide range of organisations including local authorities, housing associations, the voluntary sector and charitable bodies. The Department of Environment has also, since 1991, provided part funding to over one hundred schemes. Social services departments have begun to recognise the key role such agencies could potentially play in community care initiatives and have similarly begun to make funding available.

HIAs have been successful at securing funds for clients from a range of sources. Indeed some have pioneered the use of loans and equity release schemes provided by special arrangement, with some building societies. Local authority in-house agencies, usually based in grants departments, have tended to focus on the delivery of grant aid and these have become increasingly common following the introduction of the new

grant system in 1990, partly because it is possible to include the costs of providing the service within the grant. They frequently target their services on groups such as older and disabled people who may otherwise have problems with the application process. HIAs have an important role to play in encouraging eligible households to apply for grant aid and in providing them with help and support to ensure that they do not drop out as a result of the application process and its complexity. Moreover, in light of the 1996 changes to the grant system, HIAs can provide an invaluable service in securing finance not just for those households that are ineligible for assistance but for those who may be eligible but who in practice are unable to secure it because of resource shortages in their authority. A few local authorities have also set up more comprehensive disabled persons housing services, often with their own occupational therapy staff and these services are able to co-ordinate help with rehousing, adaptations and benefit advice (Heywood 1994). Indeed one of the case study authorities included in the national housing for health study employed in this thesis – Fordham – provides such a service through its Special Needs Housing Advice Service. The aim of this service is to secure the most suitable housing solution – by staying put in the current home as far as is possible – for those with health-related housing needs.

The general conclusion of a number of studies into the effectiveness of home improvement agencies in improving the living conditions of those they assist, has been that they provide a useful service and one that clients themselves are highly satisfied with, believing that it has enabled them to stay put when they might otherwise have been forced to move (Harrison & Means 1990; Leather & Mackintosh 1990; Mackintosh & Leather 1992).

While they may provide a valuable service for those they assist, the effectiveness of home improvement agencies in providing a comprehensive housing for health service is somewhat limited. The largest barrier relates to the limited numbers and geographical coverage of home improvement agencies. There are around only 200 HIAs in the UK and services only exist in about one third to a half of local authorities. At the time of the national medical priority project, only 42% of the local authorities surveyed operated or funded a home improvement agency. Even then, there may only be one agency, capable of serving a population of just a couple of thousand, in a district. (Heywood 1994). Provision is therefore far from universal, leading to calls for increased funding from central government, local authorities and social service authorities (Mackintosh & Leather 1992).

7.3.3.2 Equity release and shared ownership schemes

The potential for funding repair, maintenance and adaptation work for home owners – mainly elderly home owners – through home equity release schemes has been discussed by a number of commentators (see for example Leather and Wheeler 1988; Leather 1990; Leather & Mackintosh 1992; Davey 1996) as well as by the Labour Party. Home equity is already among the personal assets currently required by government to be used to pay for residential and nursing home care in old age, and the possibility of housing wealth being called upon to pay for care in the community has been highlighted by Oldman (1991) and Gibbs and Oldman (1993).

Home equity release schemes are those that use the occupier's home as security for a repayable loan, or that dispose of all or part of the equity in order to derive a sum of capital and/or a regular income for the occupier (Leather 1990). A range of commercial equity release schemes are currently available, though the main options include home income plans, home reversion schemes and rolled up interest loans (Leather & Mackintosh 1992; Davey 1996). Home income plans are the best known. They involve the client taking out a mortgage against their property to purchase a life-long annuity, payable on a monthly basis for the remainder of his/her lifetime. Some of the annuity income, however, must be used to pay the interest charges on the loan (though these are reduced by tax relief). Under home reversion schemes, a home owner sells the dwelling at a discount, either wholly or partially, to an investor, but retains the right to occupy the property for the remainder of his/her life. Rolled up interest loans (the least popular option) allow (older) people to borrow and to add all or part of the interest charge on to the outstanding balance.

Although such mechanisms for realising the capital tied up in the home have been available for over twenty years, and the indications are that modern schemes are popular among those who participate, take-up remains low at around 10,000 households in the UK (Davey 1996). A number of fundamental problems both with the principle behind equity release and with existing commercial schemes, together with the bad publicity about the experiences of people who entered faulty schemes in the 1980s has resulted in limited employment of these schemes by those who require extra disposable funds for whatever reason.

Not only are home equity release options available only to owner occupiers, but only to those home owners who own their homes outright or have largely completed paying

off their mortgage. As such the opportunities they present for releasing capital is greatest among older owner occupiers and least among younger home owners. The potential for employing home equity release also varies throughout the country. Reflecting house price differentials, this is greatest in the south of the country and less so in the north and higher in suburban and rural locations rather than urban areas. Of particular importance here, moreover, since house conditions have a negative effect on property value, and hence equity, such schemes have least potential for releasing wealth for those households who may need it most – those living in the least healthy homes.

Among existing schemes rolled-up interest loans in particular have been criticised for their riskiness, since they are tied to interest rates. Home reversion plans require the former owner to bring the property up to some fitness standard at the outset as well as maintain it afterwards, and in most cases the amount raised from the sale is well below market value. Although home income plans are the most popular, their usefulness and value as an alternative to grant aid may also be limited (Leather & Mackintosh 1992). They provide a small regular income, supplemented in some cases by a small lump sum, rather than a large capital sum to pay for comprehensive repair or adaptation. One study found that £30 per week was the most home income plans would generate (Gibbs & Oldman 1993). As such, the most popular use of such funds are simply payment of everyday expenses such as paying household bills. Few people use them for home repairs or improvements (Davey 1996).

The most important providers of home equity release schemes are a handful of insurance companies, though some building societies are also involved. The long term commitment of capital as well as an immediate cash flow to pay out annuities excludes many commercial providers from involvement (Davey 1996). These requirements may also be a barrier to any involvement of the public sector on a significant scale.

King and Leather (Joseph Rowntree Foundation 1995f) have however discussed the possibility of involving government subsidy in equity release schemes that could be targeted at those who require capital to renovate, repair, improve or adapt their homes. They propose the modification of existing Housing Corporation shared ownership programmes, in particular the rehabilitation-for-sale scheme. The works required would be arranged and carried out by the housing association, before a share of the property is repurchased by the former owner. The housing association would retain the residual share of equity and would receive government subsidy and rent from the

occupier. The required government subsidy, they argue, would be at a lower cost per unit than the present system of local authority housing grants, and as such could provide an attractive option for government. They would also provide better returns for the individual and would be more acceptable, King and Leather believe, to many than existing commercial schemes.

Despite the decline in private-sector housing association rehabilitation activity that has followed the reduction in government funding to associations (Randolph 1993), such schemes may develop further in the future as the Labour government advocates an increased role for local authorities in helping older, sick and disabled people to stay put in their homes by purchasing all or part of the home equity and carrying out the required repairs or adaptations.

7.4 Conclusion

Any group whose position in the labour market, and therefore capacity to earn, is weak will experience disadvantage in other market systems where goods and services are distributed according to ability to pay. Those with particular needs may also find that these are not met by the market if they are not profitable. People with health needs may experience both problems in the housing market. For much of the post-war period, the welfare state has been in place to counteract such prejudice in the market place. Benefits have been provided both in cash, to enable participation in the market, and in kind. In the field of housing, the state has provided accommodation directly through local authorities and housing associations for such disadvantaged groups, and within the social housing system, medical priority rehousing schemes were established for those with health needs.

In recent decades, however, direct state provision of housing has declined and increasing numbers of people, including those with health needs, have been encouraged and/or forced to enter the private housing system. At the same time, however, the housing welfare assistance to owner occupiers and private renters that such vulnerable groups depend on has been reduced. In particular the expansion of home ownership has brought with it a shift in the responsibility for housing repair, maintenance and improvement costs, and more recently, for mortgage repayments and rent costs, from the state towards the individual. This has occurred in a way that may have made owner occupation and private renting increasingly precarious,

unsustainable and unsuitable tenures for those with health needs. One of the most important points to emerge from this discussion is that over the past two decades increasing numbers of people – largely those on low incomes – have come to occupy a marginal position within the private housing system. The discussion here has shown how we might expect those with health problems to be over-represented among those in such a position. The health gains associated with a position in the 'healthiest' housing sector may be denied to those who need them the most. For others with health problems these tenures may still prove inaccessible.

What this suggests is that the gap in opportunities for those with health problems left by a reduced social housing sector may not have been filled adequately by the private housing system. Indeed there is evidence that owner occupation and private renting are increasingly hazardous to health for this group as well as others. In light of these findings and those of the rest of the thesis, the next chapter goes on to make a number of recommendations to increase the contribution of the whole housing system to the promotion of health and well-being.

8

SUMMARY AND CONCLUSIONS

A recent re-awakening of interest by the research community in the issue of housing and health confirms that the longstanding relationship between poor housing and ill-health continues to exist today. In Chapter One the evidence suggesting that a range of characteristics of the home can harm occupants' health and well-being was reviewed. Having established this, the main line of argument of this thesis has been that if poor housing is detrimental to health then the converse may also be true: that good housing can promote health. More specifically housing might be thought of as instrument of health care, and sick and disabled people might, therefore, benefit from living in, or gaining access to, 'healthy' homes. Clearly the ideal solution is the creation of a healthy stock across the board. A related aim might be at least to improve the living environments of sick and disabled people *in situ*. However, the first is a long-term goal, if it is feasible at all, and the second is often impossible or impractical given housing stock constraints and fiscal limitations. Therefore, my argument is that moving people with health needs from those parts of the housing stock that do not meet these needs, to those parts that do, represents one practical strategy of securing health gains through housing interventions.

It has also been argued, however, that the observed relationship between housing and health reflects not only the effect of poor housing on health but the effect of poor health on housing opportunities. In this light, the aim of this thesis has been to explore the opportunities available to sick and disabled people to secure the type of housing that might promote their health.

This conclusion will summarise the main findings of the thesis. In light of these it will also make suggestions on how housing policy and practice might be harnessed more effectively to public health aims. Underlying themes will be the need both for reform

of the medical priority rehousing system and increased social investment in all housing sectors. Finally, suggestions for future research will be made.

8.1 Health needs and the housing system

Smith (1990a) talks about the operation of a 'health selective' process in the British housing system whereby health status is an important determinant of people's ability to secure a home – and a decent home – in both the social and private housing sectors. What this means is that people's health needs may affect their opportunities to secure the housing they require to meet those needs and to take advantage of the health gains built into some parts of the housing environment.

8.1.1 Health needs and the social housing system

The social housing sector, council renting in particular, has, for more than twenty-five years, employed housing as a means of promoting the health and quality of life of people with health problems through the system of medical priority for rehousing (Smith 1990a). Indeed the social housing sector represents the only part of the housing system to which access – and access to the most desirable dwellings – can be gained on specifically medical grounds. This has been possible because, as an integral element of the welfare state, this part of the housing system is concerned with meeting housing need and allocates its resources on this basis. *Health* need has been recognised by housing managers as an important indicator of housing need, and there is a comprehensive system for awarding sick and disabled people priority – medical priority – in the housing queues (see Chapter Three). In other words, sick and disabled people have been selected *into* the social housing system and, in theory, health need positively affects housing attainment in this sector.

Thus, unlike other vulnerable groups in society – homeless people, single-parent families and ethnic groups for instance – who, a number of studies have shown, are often marginalised in the social housing system, particularly in terms of the quality of housing they receive (Henderson & Karn 1984; Jeffers & Hoggart 1996; Lidstone 1994; Robinson 1998; Watson 1986), people with health needs occupy a relatively privileged position in this part of the housing system.

This thesis has largely been based on the secondary analysis of the data collected in the early 1990s as part of the first national study into social housing provision for people with health and mobility needs in England (Smith *et al.* 1992). These data show that the social housing system continues to devote a large part of its allocation system to providing housing on the basis of health need. All the local authorities and most of the housing associations surveyed had in place some system of assigning priority in their housing queues on medical grounds (see Chapter Three).

Despite the widespread importance of medical priority as a key aspect of social housing management, prior to this national study surprisingly little was known about the practice of allocating housing according to specifically medical need, nor of the experience of sick and disabled people in trying to securing suitable housing through medical priority rehousing. A limited literature did however question the usefulness and future of operationalising the concept of housing for health. Chapter Three reviews this literature which suggests that medical rehousing might not represent an effective health intervention, that those health professionals who have traditionally been involved in determining health-related housing need are dissatisfied with their involvement and may withdraw it, and that geographical variations in the operation of medical priority schemes suggest that medical priority rehousing is not an equally available or effective service throughout the country.

The most fundamental challenge to medical priority rehousing (and one to which these problems are largely related), however, as some have recognised and this thesis has endeavoured to show, comes from the privatisation of the social housing system and its changed character, size, quality and geography during the past two decades.

Whenever goods and services are allocated according to some definition of need rather than ability to pay, as social housing is, demand will always outstrip supply. However, Chapter Two suggests that more than a decade and a half of radical restructuring of the social housing system by three successive Conservative governments had, by the early 1990s and still today, significantly reduced its capacity to meet the housing needs of people with health problems. The privatisation of state-subsidised housing provision during the 1980s and 1990s led to a massive decline in the size of the sector, local authority renting in particular, its quality and its affordability. This occurred, moreover, at the same time as demand for subsidised renting from a number of needs groups, including the homeless and sick and disabled people, increased (see Chapter Five). What this means is that people with health

problems are competing with other groups in housing need for a declining stock of dwellings that is, in any case, increasingly unsuitable for their needs.

Others studies have shown what this competition between needs groups for a shrinking supply of housing means for homeless people, single mothers and ethnic groups (Henderson & Karn 1984; Jeffers & Hoggart 1996; Lidstone 1994; Robinson 1988; Watson 1986). They suggest that these groups face a number of barriers to securing suitable housing as housing managers implement a range of primary, secondary and tertiary rationing strategies which restrict access to the housing system, force people to queue for a home, and determine who will get what housing. This thesis has shown that housing managers similarly attempt to regulate demand for rehousing from people with health needs in a variety of ways. As a result, sick and disabled people as a group must also negotiate a range of obstacles before securing a move into or within the social housing system on the grounds of their health problems.

Chapter Five suggests that housing managers limit access to the medical priority system by employing a range of primary rationing strategies similar to those employed in other parts of the housing system. These include failing to publicise the existence of medical priority rehousing, applying rules of eligibility for rehousing, deterring or discouraging people from applying for medical priority, and limiting their advice and assistance during the application process. Some applications are also withdrawn before they can be put forward for formal assessment, and of those applicants reaching the needs assessment stage, some are refused a medical priority award.

The effect of these strategies – whether formal or informal, intentional or unintentional – is to reduce the number of people who will secure medical priority status in the housing queues. In fact, the evidence suggests that only a minority of applicants will do so. In a context where demand for medical priority rehousing outstrips the supply of suitable housing, this might not seem unreasonable, indeed it is, perhaps, inevitable. The problem is that, reflecting the findings of other studies of the social housing rationing process, most of these strategies are not organised around the concept of need – in this case, health need. Rather, as Chapter Five shows, securing a medical priority award might relate as much to an applicant's awareness of the existence of medical priority rehousing, of the application procedures to be followed, and their ability to construct a good application, as simply to health need. Subjective judgements made by housing staff concerning how much an applicant 'deserves'

medical priority, and any other claims to housing priority an applicant might have, also affect housing application outcomes. Some means of differentiating between applicants in the rationing process do relate to health need – in particular to the *type* of health need, so that people with physical health needs are often favoured at the expense of those with mental health problems – though even these are sometimes hard to justify and are often not based on severity of health need.

What this means is that people in greatest health need may not be awarded medical priority and people in equal health need may not have equal access to medical priority rehousing. Moreover, since most of these rationing strategies are, as in other parts of the housing allocation system, informal and implemented at the discretion of housing officers and housing managers, they are not open to redress, and the inconsistency and even unfairness they introduce is not questioned.

The rationing of medical priority, unlike other types of housing priority, is not, however, a task that falls solely to the housing department and housing professionals. In the formal apportionment of medical priority, housing managers have traditionally relied on input from health professionals, especially public health physicians. In the majority of local authorities and most housing associations, health professionals provide information on individual applications, at least partly on the basis of which, needs assessment decisions are made. Moreover, at least some of these assessments are made by other health professionals in most local authorities (though not housing associations). This means that health professionals, as well as housing officials, are in a position to significantly affect the social housing opportunities of people with health needs.

The evidence in Chapter Four suggests that although health professionals – certainly those involved in making medical priority decisions – are satisfied with their role and think it is appropriate for them to be involved in housing management in this way, their involvement can be problematic. Limited collaboration between health professionals and the housing department means that medical priority decisions, unlike other housing priority decisions, are taken by professionals who have little knowledge of the housing system or of the availability of suitable housing. These decisions can therefore be inconsistent with wider housing management priorities and constraints. Health professionals' recommendations concerning medical priority rehousing may therefore be unrealistic and unimplementable. The autonomy afforded to health

professionals also means that their decisions are completely discretionary, and are rarely questioned.

In other words, the use of health professionals in the rationing of medical priority can add a further layer of bureaucracy to the allocation process, introducing further potential for inequitable medical priority outcomes to occur, and for these to be largely unaccountable.

The irony of all this – the fact that people with health needs, like other housing applicants, face a range of barriers restricting their access to the housing system – is that having secured a medical priority award, their needs can carry considerable weight relative to the needs of other groups, at the point of allocation. People with medical priority are – formally and informally – prioritised above most, if not all, needs groups in the housing queues. As a result, and as Chapter Six shows, people with health needs are in a position to secure rehousing outcomes that are favourable in terms of housing quality, health and quality of life via medical priority systems throughout the country.

However, that is not to say that all households with medical priority will do so. In some authorities medical needs in fact carry little weight in the allocation system. In most authorities housing stock constraints mean that people with medical priority are subject to a range of further (secondary and tertiary) rationing procedures before securing these healthy housing outcomes. At the point of allocation people with medical priority must compete with one another, and sometimes, with people with other housing needs, in order to secure the first and the best offers of rehousing.

Having secured medical priority, for instance, people with health needs, like all other housing applicants, must enter the waiting list. Chapter Six shows that at this point a range of factors, again unrelated to their health need, determine whether individuals with medical priority will receive an offer of rehousing and whether they will receive the offer of a suitable home. In particular, an applicant's route of entry, other housing needs, attempts to secure particularly favourable offers of rehousing and 'suitability' for particular tenancies, can affect the speed of rehousing and quality of housing outcomes.

The findings of these three chapters suggest, therefore, that as a result of the interaction of housing shortages and managerial priorities, people with health needs

face a number of barriers in their attempt to gain access to social housing that might promote their health. Moreover, since these rationing strategies often take no account of an applicant's health need, people in greatest health need may not have greatest access to medical priority rehousing and people with equal (health) needs may not be afforded the same opportunity to secure beneficial housing and health outcomes. The opportunity to employ medical rehousing in order to meet health needs is unequally and inequitably distributed among people with health needs in England. This suggests that medical priority rehousing is increasingly failing to cater not just for the majority of those in need, but to some of those in greatest need. Its capacity, therefore, to promote the health and well-being of sick and disabled people is being seriously compromised.

8.1.2 Health needs and the private housing system

If the opportunities for sick and disabled people to secure favourable housing and health outcomes through medical priority schemes in a shrinking and restructured social housing system are increasingly limited, this raises some important questions about how this group fare in an enlarged private housing system. Other studies have shown that race and gender can affect opportunities in the housing market, particularly access to housing finance (Smith 1989b; Smith 1990b; Watson 1988), but little is known about the interaction of health status and private housing attainment. This was Chapter Seven's concern.

We would expect people with health needs, as Chapter Seven reports, to experience a number of problems in that part of the housing system concerned with securing profit (rather than meeting housing need). Sick and disabled people are disproportionately poor and, for instance, are likely to face problems of affordability when housing is distributed according to ability to pay, either through failure to secure mortgage finance or inability to meet mortgage or rent costs. They might also be expected to face problems in accessing suitable housing. The private housing system does not tend to supply the type of housing required by some people with health needs and mobility difficulties. Since income is an important determinant of housing conditions in the private sector, there is also good reason to believe that people with health problems might be disproportionately represented among those living in the worst conditions. This is compounded because this is the group who are also often unable to avoid housing maintenance, repair or adaptation costs by undertaking the work themselves.

Chapter Seven suggests further that despite the expansion of the private housing system, and of owner occupation in particular, this may have become an increasingly unsuitable tenure for sick and disabled people. Conservative reform of welfare assistance to home owners and private renters has included the shift in responsibility for housing maintenance and improvement costs, and more recently, for mortgage repayments and rent costs, from the state to the individual. This has occurred in such a way as to make a position in the private housing system one that is increasingly precarious, unsustainable and even stressful for a range of vulnerable people including those with health problems. The health gains associated with a position in the 'healthiest' housing sector – owner occupation – may thus be denied to those who need them the most. The evidence here therefore provides support for Smith's (1990) assertion that people with health needs may be selected into the worst parts of the private housing stock and even out of the private housing system altogether.

The result is that not only is a restructured social housing system increasingly failing to cater for sick and disabled people, but that a restructured private housing system is an increasingly unsuitable place for this population group. What all this means then is that people with health needs may face problems in gaining access to the type of housing – in any sector – that might be expected to promote their health and well-being.

8.2 Practical considerations and policy implications

Chapter One showed that the current government recognises that tackling public health issues involves action on the housing front. The Government recognises, further, that the responsibility for this lies both with itself and with a range of housing providers, local housing authorities in particular (Secretary of State for Health 1998). This thesis has shown that good housing has the potential to secure health gains for sick and disabled people. It has also shown that this group face problems in gaining access to the type of housing with which these health gains are associated. This section will therefore discuss how housing practitioners and government policy makers might improve the effectiveness of the housing system in promoting health and well-being by meeting the housing needs of people with health and mobility problems. The first two suggestions refer to what local housing agencies can do, the third refers to the Government's role.

8.2.1 Improving medical priority rehousing

This thesis has shown that the allocation of social housing on the grounds of health need represents an effective housing for health strategy for those who secure medical priority rehousing. Chapters Five and Six also show, however, that problems in the administration and management of the medical priority system compromise this effectiveness. So although it is a shortage of suitable housing that makes it necessary to ration medical priority rehousing, my argument here is that better use could be made of the resources that do exist if they were allocated more equitably.

The health care role of medical priority rehousing depends on the system identifying those in health-related housing need and awarding them priority, and on allocating them the housing most suited to their needs. When potential demand for medical priority outstrips supply, as it increasingly does, the objective becomes one of identifying and awarding priority to those in *greatest* health need, and allocating them the most suitable housing *of that which is available.*

For a number of reasons, however, this objective is not always achieved. In light of the findings of Chapters Five and Six, I now make two general recommendations. The first of these is that medical priority could become a more equitable system by improving the exchange of information and knowledge within it. The second is that, at the point of allocation, wider housing management priorities should not, as far as is possible, over-take the aim of the medical priority system to secure suitable housing outcomes for all people in accepted health need.

Chapter Five shows that there are a number of reasons why some people with health problems have more limited access to the medical priority system than others, and that people in greatest health need do not necessarily have greatest access. As Smith, Alexander and Hill (1993) suggest, many of these relate to the insufficient information exchange at the stage of identifying and assessing health needs.

For instance, people might not apply for medical priority because they are unaware of its existence, unsure of their eligibility or unaware of the application procedures. Housing departments often fail to publicise their medical priority systems in order to contain demand. Applicants may have their chances of securing a medical priority award jeopardised by their inability to complete application forms and provide useful health information in support of their application, and yet housing officers vary in how

prepared they are to help applicants with constructing an application that might be successful. Similarly, if an applicant's GP does not provide information concerning their patient's need for medical rehousing or does not provide information that is useful to the needs assessment process, applicants may find their application is held up or unlikely to secure priority. In some authorities, medical priority applications are screened by housing officers and/or managers and some do not therefore reach the needs assessment stage. It is important, therefore, that housing staff are fully aware of housing department policy on what constitutes a suitable medical priority claim, but often they are not.

When formal assessment of health need is made by a health professional, moreover, decisions concerning the award of priority may be unfair and inequitable because they are based on an inadequate knowledge of the applicant's current housing circumstances and of housing department policy on eligibility for medical priority. Moreover, these decisions do not have to be explained or justified to the housing department or to the public. The medical needs assessment process – whether involving health professionals or housing managers – often clearly favours some types of health need at the expense of others. In particular physical health problems are favoured over mental illness and this may relate to an unawareness of the wider links between housing and health that the research community is beginning to highlight.

One means of improving the effectiveness of medical priority might therefore be to improve the information flow into and within the system at the stage of need identification and assessment: between the housing department and people with health needs; between housing managers and housing officers; between the housing department and health professionals; and between the research community and housing managers and health professionals. This would not only help to improve access to medical priority rehousing for people who are unfairly disadvantaged by a lack of knowledge of the system, but it would also help to make medical priority a more equitable and accountable system by increasing consistency in its management. Clear and consistently-applied rules and guidelines, for instance, could specify what constitutes an eligible or relevant claim to medical priority and the precise role of housing officials as *either* regulators of demand *or* advocates of applicants. If all those professionals operating medical priority – housing officers, housing managers and health professionals – work to these guidelines (perhaps developed in collaboration between them), then the system might effect more just, equitable outcomes, in terms

of who secures medical priority and who doesn't, that are also more accountable and therefore open to redress.

The effectiveness of the medical priority rehousing system, however, also depends on equitable housing allocations to those who are awarded medical priority. If health needs are a valid *independent* claim to housing priority, as the existence of medical priority schemes throughout the social sector suggests they are, then there are no grounds for allowing the same medical needs to carry different housing opportunities for different individuals and groups in the same authority.

It would not seem acceptable, for instance, to offer preferential treatment at the point of allocation to transfer tenants with medical priority at the expense of waiting list applicants, even if this leads to the freeing-up of sought-after dwellings; nor to offer 'choosy' applicants more desirable offers in order to minimise refusals. Neither is it justifiable to make less appealing offers to those groups who may be in severe need – for instance homeless people with health problems – but who are desperate for a home – any home; nor to avoid tenant resistance by not allocating 'problematic' or 'unsuitable' households to desirable neighbourhoods.

These problems arise largely because medical priority allocations are only one part of the wider allocation system and that it is in fact unrealistic to assume that medical priority can be a system that operates independently. In the context of housing stock constraints, general housing management priorities will increasingly interact with public health priorities. My argument here is therefore simply, and rather obviously, that housing managers should aim, as far as is possible, for the most *effective* rather than the most *efficient* use of the housing stock. The two are not necessarily the same, and indeed the latter objective may compromise the first.

8.2.2 Co-ordinating medical priority and other housing for health services

This thesis has concentrated on the process of residential mobility, specifically medical priority rehousing, as one means of securing health gains through housing interventions. In the context of community care, however, the idea of moving on is increasingly eclipsed by the concept of 'staying put' (Secretary of State for Health 1989; DoE 1995). And yet studies have begun to show that while in some situations

staying put represents the most appropriate strategy, moving on may still eventually be necessary, and in some instances staying put represents the least healthy option (Kearns *et al.* 1992; Leather & Mackintosh 1993a). The most effective healthy housing strategy would therefore include a range of housing options, catering for both those who live in the private and social sectors, for owners and renters, and for people for whom the most appropriate solution would be to stay put as well as for those whom it would be to move on (Elliot *et al.* 1990; Means 1996; Secretary of State for Health 1989; Watson 1997; Watson & Conway 1995). In other words, a more comprehensive local housing for health service could be achieved by co-ordinating the system of medical priority rehousing with other housing services.

Moreover, this might also represent one means of reducing demand for medical priority rehousing. There is evidence from the national medical priority project employed here, for instance, that some people with health needs are effectively forced down the rehousing route because they are unaware of the staying put options. For most of those requesting medical rehousing, health issues are the only reason for moving from an otherwise satisfactory home and neighbourhood. Some of these people clearly might welcome the opportunity to remain in the existing home if it could be made more suitable for their health needs. Yet only one or two of the 846 medical priority applicants surveyed were offered an alternative solution to rehousing on approaching the housing department.

The new strategic 'enabling' role of local authorities suggests that they are well-placed to assume the role of co-ordinating a range of housing strategies in this way. Moreover, local authorities themselves are the most important providers of other healthy housing services. In particular, local authorities operate the home improvement grant system described in Chapter Seven. The local authority survey shows that most also offer dwelling adaptations for people with walking and reaching difficulties, almost half offer home improvement agency advice, and a third provide specialist aid and advice services.

Despite this, at the time of the medical priority study, there was little evidence of a linkage of the conceptions of staying put and moving on. In seven of the nine case study authorities there were no formal procedures for offering improvement work, aids or adaptations as an alternative to rehousing. One reason for this is that housing managers are aware of the shortages of housing grant finance for home improvements in their authorities, and of the long queues for occupational therapy assessments for

adaptation work (Borsay 1982; Heywood 1994). Thus in the end, despite shortages of suitable housing, it may still be quicker to rehouse people.

There is evidence, however, from the current documentation of all the case study authorities that others are now developing their staying put services and that in some cases these are being co-ordinated with medical priority rehousing. In Hambley, for instance, a housing strategy has been developed to ensure that disabled people have access to all housing types and services and in Artown multi-disciplinary housing assessments are now carried out to ensure that older people can be allocated the most appropriate housing or be provided with aids and adaptations to their existing home, according to which option is most appropriate. These policies, of course, might be usefully developed further to include not just specific groups of people with health needs, but all those sick and disabled people approaching the housing department.

It is in Seaton, however, where the greatest shake-up of the local authority-provided housing for health service has taken place. The housing department here has developed a 'Healthy Alliances Project' which aims to widen the housing choices open to people living with AIDS and HIV by working with private sector landlords. This ensures that people can be rehoused – whether by the housing department or private landlords – as near to treatment centres as possible. Clearly this is an idea that might be useful for all people with health care needs, not just those with HIV and AIDS. Furthermore, the medical priority system itself has been overhauled. Now all medical rehousing cases are assessed by a medical assessment panel which includes a doctor, nurse, and occupational therapist. The aim of this is to ensure that all medical priority applicants secure the most appropriate assistance whether this in fact be rehousing or aids or adaptations.

These initiatives provide a step in the right direction towards achieving the comprehensive healthy housing service described above, though there is clearly still some way to go in most authorities if the housing needs of people with health problems are to be met as effectively as possible.

8.2.3 'Healthy' housing policy

It was argued above that a comprehensive housing for health strategy could be based on the co-ordination of medical priority rehousing with a range of other healthy housing services to encompass moving on as well as staying put solutions and social sector as well as private sector-based initiatives. In order to be truly effective in promoting the nation's health, however, such healthy housing practice requires the development of a coherent healthy housing *policy* at the national level.

British housing policy has, for more than 100 years, been informed – albeit implicitly for much of that time – by public health aims (Byrne *et al.* 1986; Smith 1989a). The health dimension of housing policy has never, however, been tenure-neutral. Governments have favoured different parts of the housing system at different times, and the health-promoting role of housing has tended to focus on one sector rather than another at any one time. In recent decades, the past two in particular, housing policy has once again become increasingly polarised, and, partly in consequence, health aims have largely disappeared from it. Housing policy has been more concerned with extending owner occupation and the right to wealth through it, rather than with promoting health. The effect of this, as we have seen, has been to reduce the capacity of the whole system to meet the housing needs of people with health problems, and therefore to limit the opportunities for sick and disabled people to secure health gains through housing interventions.

At a time when health policy reiterates the importance of good housing to good health, it is argued here that public health concerns must be re-introduced to housing policy, and that there is a need for a return to health-informed social housing investment but not, as so often in the past, in one part of the housing system at the expense of another. The current health Green Paper *Our Healthier Nation* (Secretary of State for Health 1998) suggests that this is entirely consistent with government plans.

Medical priority rehousing – a housing service based on state-subsidised housing provision – has been shown to represent an effective health intervention. It has also been shown, however that it is compromised in this effectiveness, above all, by a massive shortage of suitable accommodation. Over two-thirds of local authorities and three-quarters of housing associations report that their capacity to match applicants with medical needs to housing suited to those needs is limited by the extent to which demand for medical outstrips the supply of suitable accommodation. The potential of

such a system to continue promoting the health and quality of life of sick and disabled people in this way therefore depends ultimately on increasing and improving the state-subsidised rented housing stock. This might involve a reversal of the decline of social sector housing provision witnessed since 1979 but it could also include the provision of financial subsidy to private landlords to provide for people with health needs.

Reform of the state subsidy of owner occupation might also mean that this part of the housing system could similarly assume a public health role, providing housing opportunities for sick and disabled people to secure health gains through home ownership. This would require, as some have argued (Best 1995; Joseph Rowntree Foundation 1991; Webb & Wilcox 1991), a complete shake-up of the existing system of subsidy. It would involve abolishing mortgage interest and capital gains tax relief – regressive subsidies benefiting the wealthier in society – and introducing a comprehensive mortgage benefit scheme to replace the inadequate income support mortgage interest payments scheme currently in place. Assistance would be available to people on low incomes and those who suffer disruptions in earnings through ill-health or other reasons. A more comprehensive system of helping owner occupiers to maintain, improve and/or adapt their homes could also be developed, whether this be based on increasing funds to the home improvement grant system, or developing state-subsidised home equity release schemes based on shared-ownership programmes as described in Chapter Seven. Indeed, social-sector managed and government-funded shared ownership schemes might represent, as the Government has suggested in the past, an important strategy in ensuring that financial difficulty does not lead to anyone having their home repossessed or being forced to live in homes in unhealthy dwellings.

Our Healthier Nation (Secretary of State for Health 1998) refers to the 'substantial additional resources for decent housing being made available' under the Government's capital receipts initiative. This involves the release of nearly £800 million of local authority capital receipts from the sale of council housing over the next two years. This will be used to build new homes and improve the existing local authority housing stock. It will also be used to fund the repair and improvement of housing association and private sector housing. While this is a much-welcome step in accepting collective responsibility for ensuring healthy homes in all parts of the housing system, this strategy falls short of representing the type of radical healthy housing policy that I argue above is required. It remains to be seen as to whether the Government itself will recognise this.

8.3 Suggestions for future research

Much previous research into the issue of housing and health has concentrated on the possible effects of poor housing on occupants' health. Causal links have not, however, always been established. Recent studies have begun to suggest that this might be a result of the narrow approach of much of this research and its failure to explore the possibility of a wider, more complex, link between housing and health. It has been suggested here for instance that the relationship between housing and health might reflect not only the detrimental effect of poor housing on health, but that good housing may enhance health and well-being, and also the effect of health status on housing opportunities. Indeed the thesis has been able to show that a move to more suitable housing can secure health gains. But it has also shown that sick and disabled people face problems in gaining access to the type of housing that is suited to their health needs. This section will therefore conclude by suggesting how these findings might be built upon and how researchers might take forward the developments made here in order to establish a greater understanding of the relationship between housing and health and of the health selective nature of the housing system. This might moreover contribute to the development of a more effective national healthy housing policy and of local healthy housing practice.

8.3.1 The effectiveness of housing as an instrument of health care

The findings of Chapter Six suggest that despite research showing that it can be stressful and harmful to health (see Chapter One), residential mobility can also represent one means of promoting health and well-being through housing interventions.

However, the survey data employed here is based on self-reported health status and is, moreover, of a cross-sectional nature. It could thus be used to compare the perceived health of people recently rehoused under a medical priority scheme with those who are waiting to move, and to explore the perceptions of those rehoused of the health effect of their move. The data do not, however, allow for a comparison of health measures taken before and after a move for any individual. Thus although the data provide information on the way people say they experience changes in their health and quality of life following relocation, they do not provide independent evidence of the objective health gains of moving home nor evidence of the effects on health in the longer term.

Other studies of housing and health have begun to look at the health consequences of *in situ* housing solutions and the strategy of staying put in the existing home (Ambrose 1996; Smith 1997; Green 1997; Hopton & Hunt 1996a). Some of these studies (Green 1997; Hopton & Hunt 1996a) have been longitudinal. They contribute to our understanding of the health care role of good housing by monitoring the effects on health of improving the suitability of the existing home for occupants' medical needs. It is suggested here that a longitudinal study of the health gains associated with residential mobility might usefully further our understanding of the therapeutic effects of *moving* house in order to secure a home more suited to a household's health needs.

Vital to the success of this project would be the co-operation of medical, including psychological, and social science research. Much of the existing research conducted in the housing and health field has been compromised by the reluctance of these disciplines to work together. The pooling of their resources might help us to understand this complex relationship more fully.

8.3.2 Health needs and the restructured social housing system

While the national medical priority study employed here includes information on the housing opportunities for people with health needs in both the largest parts of the social housing sector – the local authority and traditional housing association systems – a further draw back of the data – and one associated with the time of completion of the project – is that we know nothing about housing provision for sick and disabled people by the new range of social landlords. Since the study was conducted at the beginning of the current decade, an important element of the privatisation of social housing provision has been the increasing momentum of local authority transfers of housing stock to alternative landlords, in particular local community housing associations and local housing companies. By 1995 more than 50 local authorities were no longer landlords, having transferred the whole of their housing stock.

Nothing is known of the allocations policies of these new landlords (Mullins *et al.* 1995), and while it seems likely that, certainly at first, they may largely resemble those of the transferring authority (not least because members of staff usually transfer with the housing stock), this is only an assumption. It is not known, moreover, how policies may change over time as the new landlord becomes established in its own right. Thus how these new providers of social rented housing cater for people with

health and mobility needs might be usefully explored to complement the information we now have on the local authority and housing association sectors.

8.3.3 Private housing for health?

The aim of Chapter Seven was to briefly explore the housing opportunities available to people with health needs in the private housing system. It was not based however only on pilot research. Indeed the question of how an enlarged housing market caters to those suffering from intermittent or enduring ill-health or disability represents an important gap in the housing research agenda. We know almost nothing of how this group fare in the market sector of the housing system.

Thus the final suggestion of this section is that a fruitful area of further research might be the exploration of the interaction of health status and housing market attainment. This indeed is the topic I anticipate developing next in a project which will include an investigation of the openness of the housing market to people with health and mobility needs, the strategies adopted by sick and disabled people in order to meet the costs of occupying, maintaining and adapting their home, and the extent to which, once achieved, owner occupation represents a healthy housing service.

8.4 Conclusion

The findings of this thesis suggest that good housing might represent an effective instrument of health care and that residential mobility is a useful strategy in securing health and quality of life gains for sick and disabled people. This depends, however, on people with health needs living in, or gaining access to, suitable 'healthy' housing. Public health concerns have largely disappeared from housing policy over the past two decades and as a result the capacity of the housing system – both social and private – to meet the housing needs of people with health problems has been compromised. The current government has begun to re-introduce the health dimension to housing policy and practice. These welcome steps must be further built upon to harness all parts of the housing system to public health aims more effectively.

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APPENDIX I: Data Sources

APPENDIX I: Data Sources

i) National Medical Priority Project

The thesis is based largely on the secondary analysis of the data collected as part of a **national study into social housing provision for people with health and mobility needs in England**, directed by Professor Susan J. Smith (Department of Geography, University of Edinburgh) and conducted between 1990 and 1992 (Smith *et al.* 1992). The study included:-

i) A telephone survey of one in three randomly selected local authority housing departments, response rate=97% (n=117).

ii) A postal survey of health advisers to local authority housing departments (included in the local authorities survey), response rate=83% (n=89).

iii) Detailed qualitative research in nine case study local authority housing departments, chosen to include a range of geographical locations, district types and housing and health profiles. In order to maintain their anonymity, the case study authorities were given pseudonyms in the original study, and these are maintained throughout this thesis. The case studies are: Albury, Artown, Fordham, Forewell, Hambley, Ingleburn, Seaton, Southplace and Westplace. The table below (using data from the medical priority project and the local authority housing and health database I compiled, as described below, shows a range of characteristics of the nine authorities.

iv) A telephone survey of all housing associations managing 50 tenancies or more in nine local authority districts (the same nine authorities included in the case study phase), response rate=88% (n=93).

Of these 93 associations, 15 had only special needs accommodation. The data employed here refers to the remaining 78 associations, and in particular, those 69 that award priority in the housing queues on health grounds.

Characteristics of the nine case study local authorities

Local authority	Authority type	Location	Household rate of limiting long-term illness	LA housing supply[1] (% change 4/81-4/91)	Demand for MPR[2] and supply of suitable housing	Medical priority management model[3]
Albury	Urban	Midlands	28.0	344 (-20)	D > S	Intermediate
Artown	Urban	North	24.6	145 (-17)	D > S	Farmed-out
Fordham	Urban	North	26.2	181 (-21)	D > S	In-house
Forewell	Rural	North	30.5	137 (-12)	D > S	Farmed-out
Hambley	Urban	Midlands	27.1	289 (-19)	D > S	Farmed-out
Ingleburn	Rural	Midlands	21.9	167 (-24)	D > S	In-house
Seaton	Urban	South	15.9	118 (-12)	D > S	Farmed-out
Southplace	Rural	Midlands	21.0	192 (-15)	D > S	In-house
Westplace	Rural	South	25.5	150 (-17)	Don't know	In-house

Notes:
1. Housing supply is number of dwellings per 1000 households.
2. Medical priority rehousing.
3. See Chapter Four for an explanation of models of management.

v) A household survey of 836 randomly selected housing applicants who asked for health problems to be taken into account in their housing needs assessment, in three of the case study authorities (Fordham, Hambley and Seaton), response rate=76%.

The sample – representing 18% of all medical priority applicants to the three authorities over a one year period – was stratified between waiting list and transfer list applicants, among those awarded and denied medical priority, and among those rehoused and those still waiting to move. The sample includes:

339 (41%) waiting list applicants and 496 (59%) transfer tenants;

349 applicants (42%) awarded medical priority, and rehoused;
189 applicants (23%) awarded medical priority, but still waiting to move;

17 applicants (2%) denied medical priority, moved anyway;
110 applicants (13%) denied medical priority, not moved;
171 applicants (20%) still awaiting medical priority decision.

The local authority break-down of this sample is as follows:

	Fordham		Hambley		Seaton	
	n	% (/256)	n	% (/388)	n	% (/192)
Awarded medical priority, and rehoused	114	45	195	50	40	21
Awarded medical priority, waiting to move	60	23	94	24	35	18
Denied medical priority, moved anyway	4	2	11	3	2	1
Denied medical priority, not moved	41	16	52	13	17	9
Awaiting medical priority decision	37	14	36	9	98	51
Waiting list applicant	137	54	120	31	82	43
Transfer tenant	119	46	268	69	109	57

Some of the findings of these surveys have already been disseminated in a series of summary reports, a 'Good Practice Guide' and in a number of papers published in academic journals. In these the survey and case study data have largely been analysed separately and at a national scale. They can, however, be linked together and with the case study information, and analysed at the local level. For instance, all those medical advisers surveyed worked in local authorities included in the local authority survey. Similarly, the nine case study authorities were included in the national local authority survey. The housing association survey was conducted in these same nine local

authorities. Moreover, the tenants' and applicants' survey was carried out in three of these. Linking and disaggregating these data was an important aim of this thesis.

The medical priority project data could also be linked to the national local authority dataset of housing and health indicators that I compiled, and describe below. In this way it was possible to gain a
wider understanding of the health profiles of the local populations, the housing profiles in each area, the operation of medical priority rehousing in the district, and how these relate to one another.

ii) National Local Authority Housing and Health Database

I compiled a national local authority database of housing and health indicators for England in 1991 to link to the medical priority data collected around this time. Housing data came from Local Authority HIP1 returns to the Department of Environment. These provide the most comprehensive and complete data available on the local housing stock, of all tenures, although data are not consistently received from each authority and returns can be incomplete. These data include a range of information on the condition of the local housing stock, numbers of households accepted as homeless by the local housing department, number of local authority lettings and local authority waiting list (though not transfer list) sizes. The data for 1991 were also linked with that for 1981, in order to enable an analysis of the change in size and nature of the social housing stock over the ten-year period of most radical privatisation by the Conservative governments.

These data are not published and are not usually available. They were provided, on request, specially for this study however.

Demographic data were compiled from the 1991 Census. Prior to this Census, information on the general health of the population was not available at the local authority level. Although mortality data is readily available, it was felt that indicators of ill-health and disability would be more useful predictors of need, or potential demand, for medical priority rehousing. This information was provided for the first time by the 1991 Census (OPCS 1994). This asked for an indication of '....any long-term illness, health problem or handicap which limits.... daily activities or the

work.... [a person].... can do'. Geographical household rates of limiting long-term illness are thought to provide an important predictor of the difference in need for health and other social services between areas (Charlton *et al.* 1994; Martin *et al.* 1995). They might, therefore, also represent a useful indicator of differences in need for medical priority rehousing between local authorities. The Census also provided information on the size of the population in each local authority in 1991.

Data from this housing and health database were employed throughout the thesis, in order to provide the context within which medical priority systems operate throughout the country. The data were particularly useful, as Chapter Two shows, in highlighting the uneven supply of social housing and possible demand for it on health grounds throughout the country. The data could also show that the geographical unevenness of the privatisation of social housing may have exacerbated the mismatch between demand and supply in many areas.

iii) Pilot interviews of households with health needs in Edinburgh

Thirty-one interviews were conducted in Edinburgh in 1990 by the English Medical Priority group of researchers in order to explore the housing experiences of people with a range of health problems. Twenty-seven households were accessed through a range of support groups and charities in Edinburgh and four through local housing associations. Those interviewed included twenty living in homes they owned or were in the process of buying, four housing association tenants, four local authority tenants, two private renters and one person living at her daughter's home. Households varied in their financial circumstances.

Interviews were semi-structured and concentrated on encouraging interviewees to talk about their 'housing careers' since their health problems developed. The project aimed to explore the housing problems faced by people with health needs and opportunities to secure housing suited to those needs.

The information was useful in supplementing that available from the tenant's and applicants' survey, particularly since it concentrated on the experience of home ownership for people with health needs. However, this was only a pilot study and

more detailed information on this issue is still required to provide a fuller understanding of the interaction of health and housing market opportunities and of the extent to which the private housing system, owner occupation in particular, is willing and able to meet the housing needs of sick and disabled people.

APPENDIX II: Published Papers

Public Health (1997) 111, 171–178

Fit for the future? A role for health professionals in housing management

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The institutions of the welfare state have traditionally catered to some health needs through housing interventions. A key strategy has been to award people with health problems and mobility difficulties priority access to council rented homes. Medical rehousing has required input from both housing managers and health professionals, especially public health physicians. This paper draws on a postal survey of health advisers to English housing departments to analyse the form, and consider the future, of this approach to housing for health.

Keywords: health professionals; housing; allocation; housing officers

Introduction

Medical rehousing is the mechanism by which people with health and mobility needs secure priority in the queues for social rented housing.[1,2] Social renting is a form of welfare transfer. It is a way of suspending the price mechanism in the housing system (through subsidies to buildings and rents) to ensure that homes are dispensed according to need as well as ability to pay.[3] This means that those whose earnings are limited by factors beyond their control, such as poor health, or whose accommodation needs are not provided for by the market, can still secure access to shelter, and to living environments that might be therapeutic.[4,5] Based on these principles, medical rehousing has been used for nearly half a century as a way to cure, care for, and/or enhance the quality of life of sick and disabled people.[5]

Historically, the assessment of health and mobility needs, and the award of housing priority on health grounds, have been the responsibility of council housing departments. In practice, the implementation of medical priority rehousing has depended on close and effective collaboration between housing managers and health professionals. There is a growing, if rather fragmentary, debate on whether and how this collaboration might continue.[1,6–13] However, the empirical basis for continuity or change is rather slim. Notably, although there have been reports on the views of housing managers[14,15] and of Directors of Public Health,[6,13], and on the role of the GP[16] there is a dearth of comprehensive information on the experiences and opinions of those health professionals who are routinely most closely involved with housing providers. The exceptions are small scale studies in single districts or regions,[12,17,18] and a recent analysis of public health physicians' more general collaborative role with local government in Scotland.[19] However, there is still no comprehensive information on the work experience, job satisfaction, views and aspirations of health advisers to housing departments; we cannot say whether local problems are widely experienced, or whether some models of housing for health work better than others. In an attempt to address these issues, this paper draws on a national survey of health advisers to English council housing departments.

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Accepted 12 December 1996

Method

A telephone survey of one in three randomly selected English housing authorities showed that most consult one or more health professionals when assessing medical need and awarding housing priority on health grounds.[20] An earlier publication used this survey to assess the role and relevance of health advisers from the point of view of housing managers.[15] What follows uses a second survey to examine the opinions of the health advisers themselves.

Of the 117 housing departments who completed the main survey (representing a 97% response rate), 114 consult a health professional when processing some, if not all, of their medical priority applications. Of these, 107 authorities were willing and able to put us in contact with the health professional they most often consult (five said they consult a variety of individual general practitioners; two withheld details on grounds of confidentiality). A postal survey containing 63 "multiple choice" questions spread over 21 pages was sent to these health advisers. An initial mailing was followed by two reminders and, finally, by a registered letter containing a further survey schedule. This procedure yielded 89 fully completed and usable replies: a high response rate of 83%, which is consistent with North American findings on the effectiveness of using certified mail in postal surveys of health professionals.[21]

The 18 non-responses include six occupational therapists, nine public health physicians and three general practitioners. Three of the occupational therapists work infrequently for their housing departments, and deemed the questionnaire inappropriate to the service they supply (that is they do not assess housing applications); two public health physicians and one general practitioner said they had been in post for too short a time to be able to answer the questions. Of the remaining non-respondents, three had left their post and had not been replaced, two were not known in the health authority we contacted, and seven provided no reason for failing to reply.

Results

Reflecting the norm among housing departments, the majority of survey respondents are public health physicians: one third (30 out of 89) described themselves as senior clinical medical officers; a further third are either directors of public health (14) or consultants in public

health medicine (14); and the remainder are consultants in communicable diseases (6) or senior registrars in public health medicine (5). The respondents include just five occupational therapists and four general practitioners (six gave some other title, and nine gave no job description). Four out of five respondents had worked as adviser to the local authority for a year or more, only seven had been in post for less than six months. Although many respondents (35 out of 89, 39%) act as adviser to a single housing department, a quarter service two local authorities and a further third (29 out of 89) service three or more districts (in which case they were asked to reply, where appropriate, with reference to the authority we had previously surveyed).

The workload of the advisers is variable: 19 (21%) assess less than 20 cases per month per authority; 14 (16%) assess 100 cases or more in the same period. The majority operate between these extremes. For the most part (55 out of 89, 62% of advisers), housing applications are received at weekly intervals; one in five receive cases less than once a week, but at least once a month; and one in ten hear from the housing department at irregular intervals. Just 10 out of 89 (11%) advisers spend 10 hours or more per week on case assessments; nearly a quarter (22 out of 89) spend only one hour. Over 2/3 (62 out of 89) assess more or less all of the local authority's medical priority applications, 12% (11 out of 89) assess less than half the cases, and 16% (14 out of 89) say they do not know what proportion of the housing department's total medical priority case load they are involved with.

Models of involvement

The main role of the medical advisers in their involvement with housing departments is to assess case information pertaining to individual applications[15]. These assessments feed into the decision of whether or not to award housing priority on health grounds, how much priority to award, and what kind of accommodation the applicant needs. To this end, however, the contribution of the health adviser varies according to how local authority housing departments manage their medical priority systems. Three management models can be identified.

(a) The *farmed-out, health professional-led* model where a health adviser (in nine out of ten cases a public health physician) is always consulted by housing managers and always makes the final decision concerning the award of medical priority. This model involves 51% (45 out of 89) of the health professionals who replied to our questionnaire.

(b) The *in-house, housing manager-led* model where health advisers are not always consulted and where the final decision on medical priority rests with the housing manager. This model accounts for 18% (16 out of 89) of the surveyed health advisers.

(c) The *intermediate* model where *either* health professionals are always consulted but are not required to make the final decision (which is left to housing managers or decided in committee), *or* health professionals are not always consulted, but when they are, they take on full discretionary powers concerning medical priority awards. Among surveyed health professionals, 31% (28 out of 89) work in this kind of system.

Overall, half the sample of health advisers work in "farmed-out" system where the whole medical priorit package is delegated to them, and where housing manage simply implement their decisions or recommendations. Th remainder are involved in systems where only selective us of health professionals is made and where housin managers retain most responsibility for assessing healt needs and awarding medical priority. Statistically it migl make more sense to allocate the two components of th intermediate model to the farmed-out and in-hous categories, respectively. However, experimenting with thi we found that the intermediate groups have more common with themselves than with the other models, an that where similarities do arise the intermediate group a sometimes aligned with in-house systems and sometime with farmed-out practices. The categories given in the te therefore provide the best approximation to the range management models actually in use, and we have chosen retain all three groups despite the (self-evidently) lo numbers of health professionals involved in in-hous systems). Later we argue that differences between th models are important, because they represent differe strategies for inter-service co-operation at a time when th whole of the welfare sector is subject to change. Firs however, we explore the role of health advisers and the relationship with housing managers in the various medic priority systems.

The role of the health professional

Health professionals play an important role in nearly a medical priority systems.[15] There are, however, significa differences (substantive and statistical) among the variou management models concerning who is consulted and wh services are supplied. Health advisers also hold differin views on how influential they are within these differe systems, how efficient, effective and appropriate their ro is, and how satisfying they find their work (all th differences between the models discussed in the text a statistically significant at $P < 0.05$ unless otherwise stated

More than four in every five (38 out of 45, 84% advisers to authorities operating a farmed-out manageme model are public health physicians. This compares with 2 out of 28 (79%) of advisers to intermediate systems and out of 16 (56%) of those operating in-house systems. Nor of the five occupational therapists in the survey servic farmed-out authorities, and in all, the intermediate and in house systems are twice as likely as their farmed-o counterparts to use an alternative to the public heal physician.

The kind of service supplied by health advisers als varies according to the management model they opera (Table 1). Farmed out models by definition afford mo autonomy to the medical adviser, tending as they do segregate the health and housing components of th assessment. Advisers working in this kind of system th concentrate their decision-making around the fact an extent of priority, though more than four in five also mal recommendations on the most appropriate type of accor modation, and nearly two-thirds specify how quick rehousing should occur. Health advisers working with th other two management models, especially the in-hou variant, display a wider spread among the various adviso functions, and evince a lesser role overall (which reflec the greater involvement of housing managers). Th

Table 1 The role of the health adviser within three different medical rehousing management models

	Model							
	All advisers		Farmed-out		In-house		Intermediate	
Role of health adviser	*n*	%/89	*n*	%/45	*n*	%/16	*n*	%/28
Determines whether to give medical priority	75	84	45	100	7	44	23	82
Determines how much priority to award	67	75	39	87	7	44	21	75
Recommends the type of home to be allocated	69	78	37	82	10	63	22	79
Recommends the location of the dwelling	38	43	18	40	5	31	15	54
Recommends how soon rehousing should occur	45	51	29	64	3	19	13	46
Provides information to housing managers	30	34	18	40	4	25	8	29
Links applicant to other services	27	30	12	27	4	25	11	39

difference is perpetuated into the appeals process, where advisers servicing in-house systems are less involved than their counterparts in areas where medical priority decision-making is farmed-out. Around one third (5 out of 16, 31%) of advisers working with in-house systems have no role in assessing appeals, whereas 66 out of 73 (90%) of all other advisers do process appeals.

The different management models imply differences in the workload of health advisers. Only 3 out of 16 (19%) of those servicing in-house systems routinely assess all the medical priority applications dealt with in their authority, compared with 39 out of 45 (87%) and 20 out of 28 (71%), respectively, of those employed in farmed-out and intermediate systems. Half (8 out of 16) of those advisers working for departments with a housing-manager-led model assess less than 20 cases per month, while almost half of those working in health-professional-led (21 out of 25), and intermediate (13 out of 28) models assess more than 50 applications per month. It follows that whereas just over half (56%) those servicing farmed-out systems spend less than four hours per week on their assessments, the figure for other health professionals rises to 71%.

Table 2 shows that health advisers in the different work environments have different views of the extent to which their input impacts on housing management decisions.

Overall, more than half (51 out of 89, 57%) the advisers believe that their recommendations on whether to award or deny housing priority on health grounds are very influential in the final decision on housing priority. This belief is, predictably, most common among advisers servicing farmed-out systems. In areas other than the straightforward award or denial of medical priority, advisers are uniformly more reserved about their effectiveness. Only one in five (19 out of 89) think their recommendations on the kind of accommodation to be offered are very influential among housing managers, and less than one in ten (8 out of 89) feel they exert significant influence on the location of properties offered. In every case advisers servicing in-house systems perceive their influence to be least.

Overall, the majority of advisers believe that their recommendations concerning the award of any priority (65 out of 89, 73%) as well as the assignation of top medical priority (63 out of 89, 71%) carry about the right weight in the system. However, this view is most widespread among those operating farmed-out systems: less than half those servicing in-house systems agree.

Table 3 shows that the majority of health advisers believe that the demands of their involvement in medical priority constitute an effective and efficient use of their time. Three quarters of public health professionals (51 out of 69, 74%) compared with just over half (8 out of 15, 53%) of the other health advisers hold this view. Most health advisers regard medical priority as a productive means of using housing solutions to meet health needs. They are,

Table 2 Health advisers' views on how much weight their recommendations carry within the housing system

	Model							
	All advisers		Farmed-out		In-house		Intermediate	
ole of health adviser	*n*	%/89	*n*	%/45	*n*	%/16	*n*	%/28
ward of mp								
influential	76	85	40	89	10	63	26	93
always followed[a]	66	73	38	84	5	31	23	82
needs more weight	11	12	4	9	4	25	3	11
ward of top mp								
influential	69	78	37	82	8	50	24	86
always followed[a]	60	67	32	71	4	25	24	86
needs more weight	15	17	8	18	4	25	3	11
ype of home								
influential[a]	63	71	35	78	8	50	20	70
always followed	29	33	15	33	2	13	12	43
needs more weight	23	26	12	27	6	39	5	19
ocation								
influential	8	9	4	9	1	6	3	11
always followed	1	1	0	0	0	0	1	4
needs more weight	11	12	5	11	1	6	5	18

Differences between models on these variables are significant at $P < 0.05$. mp = medical priority.

Table 3 The efficiency/effectiveness of medical rehousing

Is mp efficient and effective in using	Model							
	All advisers		Farmed-out		In-house		Intermediate	
	n	%/89	*n*	%/45	*n*	%/16	*n*	%/2
Health professionals' time[a]								
very much so	38	43	17	38	3	19	18	64
to some extent	34	38	23	51	4	25	7	25
not really	10	11	4	9	3	19	3	11
Housing for health needs[a]								
very much so	27	30	16	36	3	19	8	29
to some extent	55	60	26	58	7	44	20	71
not really	3	3	2	4	1	6	0	0
Public resources								
very much so	13	15	7	16	2	13	4	14
to some extent	45	51	21	53	6	38	18	64
not really	5	6	3	8	2	13	0	0

[a]Differences by management model in this response are statistically significant at $P < 0.05$ mp = medical priority.

however, a little more circumspect on whether overall it makes the best use of public resources, and this is true whatever housing management system they work for.

Despite some reservations on the efficiency and effectiveness of the procedure, fully 63 out of 89 (71%) of health advisors think it is appropriate for someone in their position to be carrying out assessments of medical priority. This view is most widespread among advisers operating farmed-out and intermediate systems, and among health advisers other than public health physicians (46 out of 69 (67%) of the latter but 12 out of 15 (80%) of the former feel their role is appropriate). On the whole, health advisers, whatever system of medical rehousing they operate, find their work in housing no more and no less satisfying than any other aspect of their job. Just under half (42 out of 89, 47%) express this view, with a tendency among the remainder to find their housing department work less satisfying (28 out of 89, 31%) rather than more satisfying (17 out of 89, 19%) than their wider duties (which are usually for the health authority).

The relationship between health professionals and housing managers

When making medical assessments health advisers say they liaise widely with other health professionals, including consultants, GPs, occupational therapists, and health visitors. Ironically, however, links with housing departments seem less well developed. There is a marked division of responsibility between housing and health matters, ar health advisers see their priority assessments as a fair self-contained task. Over 70% (63 out of 89) complete the medical assessments independently of housing manager and in the majority of cases (37 out of 63, 59%) the resul are simply handed onto housing officers without any form pattern of collaboration. As might be expected, this patter is most marked in farmed-out and intermediate systen where 34 out of 45 (76%) and 24 out of 28 (87%) wor independently (compared with 5 out of 16 (31%) operatir in-house arrangements).

As this result implies, the amount of information flowir to health advisers from the housing departments they wor with is quite limited. Most advisers have only a meag knowledge of the characteristics of the local housing stoc and of the housing allocations systems they are part o Table 4 shows, for example, that less than one in fo advisers knows how much socially rented housing (counc or housing association) is available locally, and only one three knows the length of local waiting lists. Furthermor levels of knowledge are least where we might expect the to be most: among advisers servicing in-house system This suggests that the "in-house" nature of the work do not make for better integration between housing manag ment and health advisory functions.

While general knowledge about housing among heal advisers is limited, many are routinely supplied with cas specific information on the current housing circumstanc of the applications they process (Table 5). Nine out of te

Table 4 Health advisers' knowledge of the local housing system

Type of Information	% who routinely receive information			
	All/89	Farmed-out /45	In-House/16	Intermediate/
Amount of council housing owned by local authority	22	27	6	25
Housing Association lets available to local authority	12	16	0	14
Amount of ground floor accommodation available[a]	23	31	0	21
Amount of sheltered housing[a]	29	38	0	32
Amount of dwellings at mobility standard	21	24	6	25
Proportion of stock damp or unfit	10	16	0	7
Length of waiting lists[a]	36	49	13	29
Average waiting time for those with top medical priority[a]	28	36	0	32

[a]Differences by management model in these responses are statistically significant at $P < 0.05$.

Table 5 Housing advisers' knowledge of the current housing circumstances of applicants

Type of Information	%who routinely receive information			
	All/89	Farmed-out /45	In-house/16	Intermediate/28
Time on waiting list	45	40	31	61
Type of dwelling currently lived in[a]	90	96	63	96
Condition of present dwelling[a]	67	69	38	82
Location of present dwelling[a]	83	89	50	93
Floor level of present dwelling[a]	90	93	69	96
Aids and adaptations in present dwelling	76	80	63	79

[a]Differences by management model in these responses are statistically significant at $P < 0.05$.

(80 out of 89) receive information on the type of dwelling (including floor level) currently occupied; four in five have details of locations. But only three quarters (68 out of 89) know what aids and adaptations are currently in use; just two-thirds (60 out of 89) are kept informed on dwelling condition and state of repair; and a little under half know how long each applicant has been waiting to move. Thus although case-specific housing information is more widely available to health advisers than is the more general information about the local housing stock, even this appears limited. And again, the poorest information base is found among advisers operating in-house models.

This lack of housing-related information is not, moreover, compensated for by the provision of written or verbal guidelines on the assessment procedure. What is especially intriguing here is that although "in-house" health advisers are (predictably) more likely than other health advisers to liaise informally with housing officers when carrying out their assessments, they are less likely to receive written or verbal guidelines on how to assess housing-relevant health needs. Just 25% of in-house advisers receive guidelines, compared with 62% (28 out of 45) of those in farmed out systems and 54% (15 out of 28) of those in intermediate systems.

The irony of this slim information/knowledge base is that most advisers attach great weight to general and case-specific housing information when making their health assessment. Over half (46 out of 89) the medical advisers say current housing characteristics have a bearing on outcomes "to a large extent in many cases" or "to a great extent most of the time''. This view is less widespread among those servicing in-house systems (6 out of 16, 38%) than others (35 out of 45, 56% in farmed-out systems and 15 out of 28, 54% of those in intermediate systems). However, fully 83 out of 89 (93%) of advisers, irrespective of their management model, say the effect of dwelling conditions on occupants' health is important in their decision to assign medical priority and nearly half (43 out of 89, 48%) say the location of the current dwelling is also important. Four out of five respondents (71 out of 89), the same proportion in all management systems, cite adverse housing conditions as influential in their decision to award the highest levels of medical priority available.

These housing-related variables carry much more weight than do straightforward clinical considerations. Only 23 respondents routinely give priority to people suffering from one or more named medical conditions without reference to wider facets of lifestyle and environment. In contrast, over half the advisers (51 out of 89, 57%), especially those operating in-house systems, stress the importance to their decision making of an applicant's ability to use their existing home (and none see this factor as uninfluential).

When assigning or denying medical priority, fully 85% (76 out of 89) of advisers attach importance to the likely health benefits of moving, three-quarters (66 out of 89) give weight to likely improvements in quality of life secured by a move, and nearly half (44 out of 89) say they take into account the likelihood of a suitable dwelling becoming available when assigning medical priority. Ironically, those who attach most importance to this tend to know least about the local housing system. Overall, the survey suggests that the alliance between health professionals and housing managers is not as well-developed as the long history of medical rehousing might imply. Crucially, it seems that although health advisers claim to be taking housing issues into account when making their awards, the information and knowledge base from which they are expected to do this is generally quite weak.

This difficulty is compounded by the relative lack of feedback following medical priority recommendations. Only one in five advisers routinely receives feedback on the extent to which their recommendations are implemented; and over half say feedback occurs rarely or not at all. This experience is shared irrespective of the model of management in place. Three-quarters (67 out of 89) have no access to the housing committee or to the chair or representative of that committee and half (rising to three-quarters in in-house systems) receive no guidelines on how to assess medical needs in a way that is relevant to housing officers (only 14 out of 89 receive written guidelines to this effect).

Discussion

Medical rehousing is one legacy of the longstanding alliance between housing policy and the health services. In its traditional form it combines the skills of public sector housing management with the public health function of the national health service. However, in the last 15 y the British welfare state has been radically restructured.[22–25] This has transformed both the housing system[26–28] and the national health service.[29–32] The process involves privatisation,[33] the growth of quasi-markets to replace public bureaucracies,[34,35] the expansion of the voluntary and independent sectors, and increased reliance on the safety net of the family.[36,37]

Clearly the moment has come to rethink a procedure that relies on a substantial council rented housing sector and a pre-Acheson model of public health medicine. The options are to withdraw the service altogether, to redefine it as primarily, or even exclusively, a housing management function, or to reposition it at the heart of a medical speciality (public health medicine) devoted to the promo-

tion of health, the prevention of disease and the provision of care.

The end of an era

There are some persuasive arguments for abandoning the practice of medical rehousing. Perhaps the most powerful comes from the changing size and character of the social rented housing stock. Over 20% of the council rented stock has been sold into owner occupation since 1980, at the same time as new building has dwindled by more than 90%, totalling just 1000 homes in 1983/4.[38] Today, those too poor or needy to buy are left with the least appealing dwellings, often flats in generally marginal locations.[1] The slack is supposed to be taken up by the expanding housing association sector, but this still accommodates just three percent of all households, and is itself subject to fiscal stringency.[28,39,40] Moreover, this sector may be less geared to the principle of housing for health than is council renting.[41] Overall, therefore, public housing investment in Britain fell by 37% in real terms between 1979/80 and 1993/4, and in the last ten years the size of the social sector diminished by thirteen per cent. The problems of operationalising the idea of medical rehousing in this context underpin the frustration and disillusionment evinced by some health advisers.[12,13,42] Fully 45% of the health advisers we surveyed think the system cannot be improved because of the extent to which demand from people with health needs outstrips the supply of suitable accommodation.

A second, related, reason for abandoning medical rehousing is that the idea of moving on has been eclipsed by the concept of staying put, in the context of community care. There is some evidence that people with health needs are effectively forced into rehousing because of the lack of *in situ* alternatives,[5] and there are some people whose health needs are best served in their existing home.[11] In a policy context where the balance of housing interventions might be expected to shift from rehousing to rehabilitation, it could be argued that the effort spent on medical rehousing could be better invested into the management of community care.

Despite these problems, it is hard to argue against the continuation of some form of rehousing for health. There is at least some evidence to suggest that, in health terms, the rehousing service may work: medical rehousing can, to some extent, alleviate symptoms, improve health, prevent disease and enhance the quality of life.[5,7] It is, moreover, increasingly clear that the path towards making effective community care assessments requires provision for moving on as well as to stay put. Research shows that either strategy can be stressful, either can be therapeutic and both are important to any comprehensive housing for health policy.[43–45] Furthermore, we know that demand for housing from people with health problems is increasing, that health issues continue to dominate local authority housing allocations policies, and that there are few options for many families with health needs in the market sector of the housing system.[42] Health problems continue to generate housing needs and these require some kind of policy response.

In short, to abandon the medical rehousing service would fly in the face of the most recent trends in health and housing policy. Health policy continues to stress the view that public health is no longer the exclusive domain of health professionals, hospitals, the NHS and the Department of Health.[46] Instead, there is to be a health dimension to all public policies, built around a suite of health alliances. To this end, most documents concerned with the nation's health in recent years have stressed the importance of healthy housing. Additionally, current thinking in housing policy stresses the government's continuing commitment to social renting in a housing system where "landlords meet identified local needs and priorities... and tenancies are allocated to those in housing need".[47] This same document notes that "housing departments have a key role to play in implementing community care" (p. 38) endorsing the earlier assertion that "Housing is a vital component of community care and it is often the key to independent living" (p. 25).[48] In short, the arguments in favour of enhancing the alliance between housing managers and health professionals seem at least as persuasive as those which stress its weaknesses. To conclude we outline two possibilities for retaining a housing for health service.

Health as a housing issue

Even if health problems and mobility difficulties continue to have a place in the definition of housing need, it could be argued that identifying and prioritising such needs should be primarily a housing management function. That is, the in-house model should become the norm for the management of medical priority. The arguments for minimising or removing the role of the health adviser are as follows.

Crucially, it has been argued that, given the limited supply of housing, a medical qualification is not required to distinguish between who does and who does not have eligible health needs.[12] Ever since the Acheson report there has been concern that public health physicians should avoid roles that non-medical personnel could fill. The consensus is that medical assessments for housing departments are one of these.[6,13,49] Over one third (31 out of 89, 35%) of the surveyed health advisers think trained housing managers would draw the same line as they do between those who should and should not receive medical priority most of the time. Nearly three-quarters (64 out of 89, 72%) said this would sometimes be possible. In a recent study, similar gradings were allocated by housing managers and health professionals in all but 12% of cases, and discrepancies were only potentially disadvantageous to half of these.[50] Thus the evidence is in sympathy with just over half the surveyed health advisers who think that improvements in the efficiency and effectiveness of the medical priority system could be secured by making more use of specially trained housing officers.

An in-house model may also be preferable from the point of view of effective and accountable housing management. The survey shows that while all health advisers place weight on housing factors in making a priority award, few know enough about local housing systems to be able to do so fairly. Farmed out system could thus be criticised for undermining local authorities control of some important housing decisions,[51] without safeguarding accountability for these decisions. In the process, housing managers are encouraged to believe that they, themselves, do not influence medical priority outcomes, when all the evidence suggests they do.[41]

Finally, medical priority does not happen in isolation from the rest of the housing needs assessment and

allocations process. Against a background of rising demand from a variety of needs groups, placing medical rehousing squarely into the same arena as other priority rehousing claims could make for a more integrated system and a fairer balance among all priority needs. It could also reverse a trend towards the medicalisation of public policy which some see as highly undesirable.[52,53]

To an extent, these persuasive arguments for reducing the role of the health adviser are built into the in-house management model discussed in this paper. Moreover this is the model most popular among housing associations which are now the most rapidly expanding part of the social rented sector.[14] Nevertheless, we find three arguments against adopting an approach which includes only a minimal role for the health adviser. First, the medical rehousing process has been shaped by housing and health professionals together, and there is a wealth of experience and expertise invested in this partnership, which has often been a successful one.[15] Second, although some prominent public health physicians argue that medical rehousing is an inappropriate role for the discipline to sustain, our survey suggests that most of those actually involved in the work feel it is important, effective and appropriate. Finally, the scene is set in national housing policy for social housing to be split among a variety of landlords across the public and private sectors. Notwithstanding the new enabling and presumably co-ordinating role of the local authorities,[54] the trend is towards diversification and fragmentation. If lettings decisions are left to an array of private landlords, there may be few obvious possibilities for consistency and accountability in the area of housing for health. This suggests it is worth at least exploring an alternative model for the future of medical rehousing.

Medical rehousing is a public health issue

It is now clear that health advisers play a key role in nearly all local authorities' systems of awarding medical priority for rehousing, that they exert more influence than they realise on the system as a whole, and that their role is highly valued by housing managers.[15] Those who exert most influence work in "farmed-out" systems. They are mainly public health physicians, they are enthusiastic about their work, see it as a good use of time, and believe they are the appropriate person to do it.

Public health medicine is in the process of re-examining its priorities and re-establishing its importance.[19,55–58] It may not be too radical to suggest that as a part of this health professionals could take a lead in shaping the role of housing as a health intervention; that they may redefine, rather than remove, their contribution to the needs assessment and allocations process for social rented housing.

This redefinition could be based on the following points. First, medical rehousing is as much about public health and social care as about providing shelter. Second, as the social rented housing segment fragments, there is increasing need to secure consistency between landlords in how health needs are built into access and allocations procedures. Third, there is increasing need for a view on how to link rehousing with other service interventions designed to promote health and deliver care, especially in relation to community care. This may imply an increased role for a range of health professionals from occupational therapists to family practitioners. However, the strategic demands of managing housing for health seem entirely appropriate to a discipline – public health medicine – whose core agenda is to foster policies which promote health.

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Pergamon

Health & Place, Vol. 3, No. 4, pp. 203–216, 1997

Printed in Great Britain
1353-8292/97 $17.00+0.00

PII: S1353-8292(97)00015-4

Rehousing as a health intervention: miracle or mirage?

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The relationship between housing and health is complex, and despite a recent revival of interest, many facets remain unexplained. Most research focuses *either* on the impact of housing environments on occupants' health *or* (less often) on the consequences of health status for housing attainment. One link between these perspectives is the residential mobility (or otherwise) of people with health problems. Residential change is usually thought of as stressful, and, if anything, harmful to health. However, welfare state societies have traditionally used rehousing as a way to improve the accommodation options for people with health and mobility needs. This paper draws on a survey of over 800 British households to explore the effectiveness of rehousing as a health intervention. It shows that the housing system can be health selective in favour of sick people. However, success in breaking the link between housing deprivation and health inequalities depends on retaining a social role for housing policy.

Keywords: housing, health, welfare, migration

Introduction

The interaction between housing and health is complex. The harmful effects of draughty, damp, cold, mouldy, overcrowded and structurally suspect homes have long been assumed and are increasingly well-documented (Smith, 1989; Ineichen, 1993). Housing conditions have been associated with both physical and mental health problems, even controlling for lifestyle and class (Packer *et al.*, 1994). Children's living conditions may predispose them to 'unhealthy life careers' (Lundberg, 1991, Lundberg, 1993), and poor housing environments may depress the survival rates of frail older people (Zhao *et al.*, 1993). Housing variables make deprivation indicators a good proxy for morbidity (Payne *et al.*, 1993), and it is increasingly clear that 'Tackling inequalities in housing also addresses health inequalities.... Good housing and good health go together' (Best, 1995).

One arm of the growing housing and health research community is thus concerned with the way that housing affects health; with how and why people's residential location impacts on their odds of getting sick or remaining well; with 'who gets what, where' in the epidemiological sense of the phrase. Another, much less explored arm of this literature is concerned with how people's health status—their experiences of health, illness and disease—affects their housing opportunities. Compared with geographers' interests in how other attributes and categorizations (around themes such as gender, 'race' and age) affect housing outcomes, this is a sorely neglected area. However, research has begun to show how people with health problems can be marginalized in the housing system, gaining limited access to homes suited to their needs (Elliott *et al.*, 1990; Smith, 1990, 1991, 1993; Kearns and Smith, 1993; Kearns *et al.*, 1994). Poor health affects housing attainment, so that people with health problems have the double burden of living with illness in unhealthy homes.

In practice, the relationship between housing and health is made up of both the impact of housing on health, and the impact of health on housing outcomes. One link between these hitherto rather distinct areas of work is the residential mobility, or immobility, of people with health problems. A focus on the movement of people with health problems within a housing system of varying character, quality and condition, is one route to understanding the spatial and social patterning of health. Extending Macintyre's (1994) argument, we identify this as an important challenge for social science.

There is a small but growing literature in social medicine on the health effects of moving home. In it, most emphasis is placed on the psychological distress associated with residential change, especially where this is prompted by reasons beyond

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the movers' control (Hartmann, 1964; Syme *et al.*, 1965; Kantor, 1969; Rowland, 1977). Such mobility has been conceptualized as one of those stressful life events that precipitates both mental and physical illness (Rabkin and Struening, 1976; Byrne and Whyte, 1980; Jacobs and Charles, 1980; Metzner *et al.*, 1982; Brown and Harris, 1989), and it is an upheaval that can be particularly depressing for women (Weissman and Paykel, 1972), and worrying to older people (Kasl, 1974; Dimond *et al.*, 1987).

There is, however, also evidence that, in some circumstances, staying put can be just as stressful as moving (Ineichen, 1993; Leather and Mackintosh, 1993), and it has been argued that some forms of residential mobility can be therapeutic (Stokols *et al.*, 1983; Kearns *et al.*, 1992). In considering the relationship between residential mobility and public health, what is important, it seems, is not simply whether people move or stay, but rather the relationship between housing needs, on the one hand, and the economic and social costs of attaining or sustaining the accommodation required to meet these needs, on the other.

In Britain, there is one widely practised form of residential mobility which is explicitly designed to be therapeutic, in that it aims to provide housing opportunities for those who want to move because they have health and mobility needs which cannot (for a variety of reasons) be met *in situ*. The practice is known as medical priority rehousing (MPR), and it is a means of ensuring that some groups of sick or disabled housing applicants are given high priority in the queue for state-subsidized rental accommodation (Smith, 1989, 1990, 1991). MPR is a way of using housing interventions to interrupt the spiral from poor health to poor housing, and to break the link between housing deprivation and health inequalities.

The practice of MPR means that a large subsystem of British housing (the social sector, accounting for around 70% of the rented housing stock) is deliberately health selective. This reflects the relevance and importance of housing provision to the aims of the welfare state. In terms of the welfare ideal, there are at least three reasons why social housing might be expected to meet the accommodation needs of people with health problems and mobility difficulties. First, public housing is itself a form of welfare transfer, designed to offset in kind the income inequalities that arise in a market economy where, for instance, those who are sick have less potential to raise income in the workplace than those who are well. Second, public housing has traditionally filled the gap between the kinds of homes some sick and disabled people need and those which are regarded as commercially viable by the market sector. Third, an expanding public sector was regarded from the mid 1940s and for more than 30 years, as a way systematically to replace the inadequate, overcrowded, over-priced and unhealthy homes of the inner cities with an affordable (subsidized) alternative, built to minimum standards, that would be centrally monitored, managed and maintained.

British public policy has, in short, carved out a uniquely social role for housing which links it both to the public health movements of the late nineteenth century and to the welfare state of the post war years (Spicker, 1989; Clapham *et al.* 1990; Arblaster and Hawtin, 1993). Amongst other things, this has fostered the assumption that rehousing can be an effective health intervention—that residential change can alleviate suffering, cure illness, enhance access to care or improve quality of life. MPR is therefore part of a tradition wherein a substantial proportion of the British housing stock is made available according to some measure of 'need' rather than ability to pay; according to a social rather than a commercial contract.

Social housing provision in Britain has historically been a local government responsibility although since the late 1980s, an expanding voluntary or 'independent' sector has taken on part of this role, and it is anticipated that future social investment may be directed through private landlords too (Department of the Environment 1995). Currently, nevertheless, virtually all local authorities and most housing associations award some priority in their housing queues to people with health and mobility problems, and this is the main way that sick people move out of, or avoid moving into, unhealthy homes (Smith *et al.*, 1991). MPR is thus available to tenants who wish to move within the social rented sector (transfer tenants), as well as to households currently living in owner-occupied or privately rented accommodation (waiting list applicants).

Considering how widespread the practice is, MPR has been subject to surprisingly little scrutiny. The majority of research, moreover, is based on small scale studies of the experience and opinions of housing managers or health professionals. Looking from the top down, many studies emphasize the limitations of MPR and are critical of its achievements (Fisk, 1984; Parsons 1987; Connelly and Roderick, 1991). Despite this, the effectiveness of rehousing as a health intervention for individuals and households is, while frequently alluded to, rarely examined. Just whether and how parts of the British housing system really are health selective, and the extent to which this selectivity adjusts housing outcomes to health needs, has still to be explored.

Crucially, there is as yet relatively little information on the views, preferences and experiences of those segments of the general public who want to move, and who see MPR as a potentially effective way of meeting their known health need

This is ironic at a time when notions of quality and consumerism have become central to the British government's thinking about how best to manage the public sector (Connolly *et al.*, 1994). Very few studies have considered whether the moves that do take place are successful in health terms, and those that have are equivocal (Thomas and Yarnell, 1978; Elton, 1983; Maclennan *et al.*, 1983; Elton and Packer, 1986, 1987; Golding, 1987). Existing studies are, furthermore, small in scale and targeted towards particular client groups in a single administrative area. In practice, demand for MPR stems from a broad cross-section of the public: people unable to afford a home in the housing market, those whose health and mobility needs are not catered for commercially, and those whose homes are harming their health, restricting their independence, or limiting their access to care. The relevance and effectiveness of MPR for dealing with the general housing needs of a wider range of people with health problems and mobility difficulties has not, so far, been examined. This facet of residential mobility—one part of the link between housing environments and health status—is the topic of this paper. In developing it, we are mindful of Kearns (1993) interest in the expanding horizons of medical geography, particularly in the direction of renewed concerns for social justice.

Method

This paper aims to fill a gap in the literature on the health effects of residential mobility (and immobility) by reporting on the experiences of over 800 randomly selected medical priority applicants for council housing in three metropolitan districts in the North, Midlands and South of England. To comply with a confidentiality agreement, we are unable to identify the case study authorities by name, though where appropriate, we do examine some differences between them. The survey, completed between June and August 1991, is part of a larger study of the nature and effectiveness of housing provision for people with health problems and mobility needs in England (Smith *et al.*, 1992).

The survey was conducted only among those seeking to move into or within the council rented housing stock, and was limited to housing applicants who asked for health and mobility problems to be taken into account in their housing needs assessments. A total of 836 households was interviewed (representing 8% of all medical priority applicants to the three authorities over a one year period to May 1991). The sample was stratified to enable comparisons within the group awarded medical priority ($n = 538$) between those successfully rehoused ($n = 349$) and those still waiting to move ($n = 189$). We also interviewed 127 households who had been denied medical priority and 171 applicants who were still waiting to hear the outcome of their claims.

The three participating authorities initially issued a total of 1815 addresses from their records of households who had requested MPR. In every case, we were required to screen the households by post, to give them the option not to be visited by an interviewer. We received 156 (9%) refusals at that stage (mainly from one local authority district, where households were required to reply if they wished to participate, rather than if they wished to decline). We had no information about the households at the screening stage, therefore the characteristics of those who opted out of the study are not known. Of the remaining 1659 addresses, 562 (34%) were excluded because they proved to be outside our specified sampling frame. They referred to empty or non-existent dwellings, to households who had not lodged a medical priority application, and (in a few cases only) to households where the contact person had died.

After excluding ineligible addresses, we were left with a usable sample of 1097 yielding a response rate of 76% ($n = 836$). The non-response is accounted for equally by those not contacted after four call-backs and by those who could not be interviewed because they were in hospital, had a language difficulty or refused. More waiting list applicants were lost than transfer tenants, and a slightly higher response rate was secured from those rehoused under medical priority than from those who had secured medical priority but were still waiting to move. In the end, 59% of those interviewed were waiting list applicants and 41% were transfer tenants, while the distribution of the sample across the case study authorities broadly reflects their relative sizes (46% in the midlands, 31% in the north and 23% in the south).

While the main interview always took place with the applicant who had mobilized the medical priority request, overall the survey includes data relating to 1046 people whose health problems were reported to the local authority as part of their family's housing application (105/836, 13%, of applicants asked for the health of more than one household member to be considered). Nearly two-thirds of notified health problems (673/1046) involved physical health problems only; nearly a quarter (236/1046) refer to both physical and mental health problems; and 13% (137) suffer from mental health problems only. Many people (404/1046, 39%) asked for more than one named condition to be taken into account, and 153/1046 (15%) say they named four or more problems when submitting their application forms.

One aim of the study was to provide a perspective on the relevance and effectiveness of MPR from the point of view of service consumers. The questionnaire is therefore based on applicants' own views of how their self-reported health

interacts with the housing system. The use of self-reported health is justifiable in this context, since it is people's perception of their health needs that leads them to try to mobilize caring services (Fylkesnes and Forde, 1992). Furthermore, *how* people experience their health or their symptoms of ill-health largely conditions their beliefs about how effective (and sometimes how satisfactory) particular interventions (including rehousing) have been.

Housing for health: users' views

The tenants and applicants' survey provides a perspective on MPR based on the experiences of people whose health problems and mobility difficulties prompt them to seek rehousing. Our primary interest is in who gets rehousing, when, where, why, and with what (health) effect. First, however, it is worth making a few preliminary observations on how the service is viewed by its users. While the idea behind MPR stems from a long British tradition of using housing interventions to secure public health and social policy goals, it has not previously been clear that the general public see the service in this way. Studies based on the views of housing managers and health professionals often instil the idea that people who request medical rehousing are primarily concerned with securing a better overall housing package. Health needs, it is suggested, are included as a secondary consideration: people decide they wish to move and then gather as much evidence as they can—including poor health—to advance their position in the housing queues. Our data, however, suggest that while this approach may be adopted by some households, the majority of applicants hold quite a different view.

In practice, well over half those interviewed (497/836), and as many as 70% of in one of the authorities, *only* wish(ed) to move because their health and mobility needs are so pressing, and most of the remainder (302/836) say health was at least as important as other housing needs in motivating their application. Hardly anyone regarded health problems as incidental to a rehousing application which was lodged primarily for other reasons. Indeed, nearly three-quarters of applicants who applied for medical priority but are still waiting to move (359/470, 76%) feel they currently live in a neighbourhood which is as good as, or better than, others in the district; and most of these applicants (272/470, 58%) are satisfied with their existing neighbourhood situation. This is true for waiting list and transfer tenants alike. Medical priority applicants, it seems, do see health as a housing issue and, on the whole, they regard health concerns as the centre-piece of their rehousing claim. MPR is regarded as a health intervention first and a housing service second, and this view is held by applicants in all three case study authorities.

The extent to which housing provision functions as a health intervention is reflected in the experiences of those who secured a priority grading. Of the 538 interviewees who had been awarded medical priority, 14% (77/538) say this had led, or would lead, to an immediate offer of rehousing, and over a third (182/538) believe they had secured, or would secure, a quicker offer than those without medical priority. This is an accurate perception which reflects the fact that medical priority is sufficiently important in the majority of housing allocations schemes to secure prompt rehousing for the most urgent cases (Gardner and Troop, 1981; Guichan, 1993; Smith *et al.*, 1994). Interestingly, it is in the authority with the smallest stock, and the highest ratio of applicants to accommodation, that applicants are most pessimistic about the scope for housing interventions to meet health needs. Here just over half those awarded medical priority, compared to only a quarter in the other districts, thought their priority grading would make little difference to their housing outcome. Nevertheless, they still view their move as a strategy to improve their health, not simply a means of upgrading their home.

It is, furthermore, clear from the survey that householders in all three districts tend to experience their actual or potential move as something forced on them, either to prevent their health deteriorating or to enable them to maintain independent living in the face of a disability. (Despite this only three respondents were offered *in situ* home adaptations and/or care packages to enable them to avoid the prospect of moving.) The implication is that medical priority applicants fall into a group—those forced to move—for whom residential mobility is likely to be stressful or detrimental to health. Such applicants might be seen as doubly vulnerable to the health risks of residential change: prompted to move because of their health; yet acutely aware that by staying put they could put their health at risk. Such risks were indeed uppermost in the minds of many interviewees. Among those who, at the time of the survey, had either been refused medical priority or were still waiting to move, nearly two-thirds (306/487)—rising to 79% in the most pressurized authority—felt that the delay had been detrimental to their physical or mental health, and a quarter (133/488) had been, or believed they would be, hospitalized as a consequence. The question we seek to address therefore, is whether being forced to move for health reasons is, by virtue of the potentially advantageous outcomes secured through services like MPR, ultimately less stressful or detrimental to health than being forced to stay put. Is residential mobility one route for sick people into healthy homes and enabling environments?

Rehousing as cure?

Although rehousing, like any housing intervention, might, in theory, be thought to have a range of therapeutic effects (Conway, 1995), in practice, the model driving MPR has been a medical one. Over 90% of English local authorities award medical priority on the grounds that people's homes are harming their health or on the assumption that rehousing would lead to health improvements, whereas only 70% are sympathetic to the claim that rehousing would improve access to care or improve the quality of life (Smith and Mallinson, 1997). Moving home is seen, in short, as a way of removing the cause of, or in some way 'treating', an illness.

As noted above, the applicants' survey is based on self-reported health, and on public perceptions of the health benefits of moving. It is, moreover, a cross-sectional rather than a longitudinal study. It can compare the health of recent 'movers' and of those who are currently 'waiters'; it can compare the experience of health and illness among those awarded and those denied medical priority. It can ask 'waiters' to comment on why they believe a move is necessary for their health, and it can capture 'movers' reflections on changes in their health status. It cannot, however, compare health measures taken before and after a move for any individual. The survey does not, then, provide independent evidence of the objective health gains of relocation, but it does illuminate changes in how people think about and experience their health (which in turn affects their satisfaction with the housing service, and their demands on the health services). This sheds light on the curative and palliative functions of rehousing in the following ways.

First, it is overwhelmingly the case that those rehoused under a MPR scheme feel they have moved to a healthier home. The variations between local authorities on this are small, and the generalization holds for both transfer tenants and waiting list applicants. Nearly two thirds of interviewees (220/349, 63%) say the dwelling they have moved to is in better overall condition than the one they left, and over half (181/349, 52%) say there is less damp in the new home and that the home is easier to heat adequately (183/349). Some problems which may be hazardous to health do remain after rehousing, but these are much less widespread among the rehoused population than among those waiting to move. Table one confirms that those rehoused generally live in dwellings that are in better repair, less likely to be damp or infested, easier to heat, and less draughty, noisy and overcrowded than those still waiting to move. The rehoused group are therefore less likely to be exposed to the problems most often implied by the term unhealthy housing.

Second, in addition to perceiving themselves to be living in healthier homes, 61% (213/349) of medical priority movers associate their new dwelling with a change for the better in their own general health. Fully 30% (106/349) now describe their health as good or excellent and over one third (133/349, 38%) can identify one or more conditions which have improved since the move. These health improvements may or may not be due to the qualities of the new dwelling, but they are certainly associated in the public mind with having gained access to healthier homes. The small area differences in these figures, moreover, tend to suggest that people who move to healthier homes experience health gains which are in proportion to their improved living conditions. In the northern case study, the housing problems listed in Table 1 are less widespread among all medical priority applicants (whether rehoused or not) than in the other local authorities. Additionally (and partly as a consequence) the reduction in the incidence of problems between those rehoused and those still waiting to move is smaller in this northern authority than in the midlands or the south. This difference in housing-related 'health potential' is

Table 1. Housing problems experienced by medical priority applicants

Major problems with current dwelling	Those rehoused for health reasons % (/349)	Those who have not (yet) moved % (/470)
Damp	11	32
Mould	8	23
Poor repair	14	30
Hard to heat	24	42
Draughty	20	42
Dry rot woodworm	3	9
Other infestation	9	14
Noise	10	29
Lack of amenities	3	13
Overcrowding	2	24

Column entries show the proportion of those in each group (those with medical priority awarded and rehoused and those who are still waiting, with or without medical priority, to move) who experience each feature as a major problem in their current dwelling.
All the listed differences between 'movers' and 'waiters' are significant ($p < 0.05$).

Table 2. Reported changes in health service use after medical rehousing

Service used	Frequency after rehousing			
	More	Less	Same	Can't say
Family doctor	21	22	57	1
Consultant / specialist	14	24	59	3
Outpatients	14	22	63	2
One or more nights in hospital	14	30	52	4

Table entries are row percentages out of 349 medical priority movers.

reflected in medical movers' perceptions of their actual health gains following rehousing: compared with applicants in the midlands and the south, fewer of those in the north associate their move with improvements in their general health (though even here, half the rehoused medical priority applicants experienced health gains).

Of course, both housing managers and applicants are aware that some health problems are more likely than others to be affected by moving. Older people, for example, are more likely to suffer from degenerative illness than their younger counterparts. Thus it is people under the age of 35 who are most likely to have experienced health improvements following rehousing: 46% of these say one or more conditions have improved since moving, whereas the figure for the over-65s is only 32%. Specific conditions which respondents are least likely to feel have been affected by relocation include, predictably, learning difficulties, metabolic disorders, skin diseases and diseases of the intestine, liver, kidney or bladder. Over two-thirds of people experiencing these health problems before their medical priority move experienced no change in the condition after the move. In contrast, the conditions most likely to be reported as having undergone a change are mental illness and depression. Over two thirds of people suffering from these mental health problems experienced a change following their move, and the majority (41/73, 56%) say their condition improved (a finding consistent with that of Elton and Packer, 1987).

Third, it is clear that the 'medical' model of MPR is not concerned only with health improvements—a move could be regarded as a health gain if it arrested the pace of a progressive illness. It is in this light that we might view the finding that although only one in 10 applicants has experienced any new symptoms since moving, 111/349 (32%) have experienced a worsening in one or more conditions. This experience of deteriorating health is, on the one hand, strongly related to age: only 10% (15/144) of under-35s, compared with nearly half (57/129) of those over 65 experienced a worsening in one or more conditions following their medical priority move. On the other hand, continued deterioration in health is most markedly associated with a few conditions which might be expected to become progressively worse over time, irrespective of *any* health intervention. Over half those experiencing problems with vision (21/37, 57%), for instance, said that their eyesight had continued to deteriorate following the move, and nearly a third (90/293, 31%) of those with walking, stretching and reaching difficulties say that the difficulties (though not necessarily their ability to live with them) got worse after moving. It is, however, worth pointing out that people suffering from similar mobility problems, who had moved into their present dwelling *without* the privileges associated with medical priority, were even more likely to have experienced a deterioration in their condition. Over two-thirds (57/85, 67%) of the non-priority movers said that their walking, stretching and reaching difficulties had become worse since moving into their present home. The non-priority group are, it seems, twice as likely as the priority group to have experienced a worsening in this aspect of their health following relocation.

The alleviation of symptoms is one rationale for using housing interventions to meet the needs of people with health problems. It is, indeed, the rationale most often forwarded by housing departments for engaging in this practice. The evidence is that when judged on this criteria, MPR can, from the perspective of housing consumers, be successful. This success is all the more notable given that the origins of the move for many applicants is a stressful one. A similar outcome has been observed in at least one other welfare society (Kearns *et al.*, 1992).

Although it has been suggested that the health gains of residential change may not last for people with some types of problems, especially mental health problems (Elton and Packer, 1986, 1987), the evidence from our survey is that in the short term, at least, the health improvements people associate with rehousing can also produce health service savings. The majority of movers do not associate rehousing with either an increase or a decrease in the frequency with which they use the various health services, but among those that do identify a change, the majority use these services less. Table 2 shows that, since moving, one in five respondents make less call on their family doctor and less visits to outpatient departments, one in four make less use of consultants and specialists

and nearly one in three say they have spent less time in hospital. This is not a function of diminished access to care, since most movers found access to services and support unaffected by their moves, and where access levels did change, they were generally enhanced (see Table 3).

The findings discussed so far suggest that medical rehousing—one route for sick people into healthier homes—does have some palliative or curative effects. It is one way of breaking into the cycle which links housing outcomes with health inequalities. This is not to claim that it is the only solution, or the most appropriate strategy, for all people who are sick or who live in homes which harm their health. Any effective healthy housing strategy must accommodate those who wish to stay put as well as those who need to move on (Watson and Conway, 1995). Capital investment in the housing stock in addition to effective and equitable means of matching dwellings to needs is required to turn residential spaces into healthy places. What our findings confirm is that, within this wider framework, moving home is one of several housing strategies with the capacity to secure health gains.

Rehousing for care?

Health interventions are not only, or even mainly, about providing a cure. Access to the care needed to prevent illness and promote health is equally significant, and, indeed, currently more in vogue in British public policy. However, compared with local authorities' readiness to rehouse with a view to improving health, and surprisingly given the political centrality (albeit increasingly qualified) of ideas about community care, there is less explicit commitment to awarding housing priority to those who may not expect health gains from a move, but who need better access to caring services (Smith and Mallinson, 1997). Accordingly, as noted above and detailed in Table 3, in terms of access to formal health care opportunities, there is little difference in the proportions of medical priority and other movers who feel their access has improved. The fact that so many movers overall experience enhanced access to care may, nevertheless, signal the extent to which the location of caring services conditions any choice that people with poor health might have in their residential destination (Meyer and Cromley, 1989).

Perhaps the most important finding illustrated in table three is that those rehoused on health grounds appear to be in a better position to receive *informal* caring services than other recent movers. One in three (113/349, 32%) medical priority movers, but less than one in four (43/190, 23%) other movers, claim better access to close relatives following their move. This tendency is most marked in the northern case study and least common in the south. Similarly 38% of medical movers but just 17% of other movers say their social support networks improved with moving. This difference is marked in all three case study authorities, but it is especially prominent in the south. In all, therefore, medical movers have more access than their non medical priority counterparts to informal caring networks, and the advantage obtains irrespective of where they live, and of whether they are waiting list applicants or transfer tenants.

Although the idea of community care revolves around strategies for staying put, our survey suggests that for some people rehousing is an equally effective way of enhancing access to care (see also Leather and Mackintosh, 1993). Simply ensuring that people live in appropriate and affordable housing is a key component of care and support for people with health problems (Laws and Dear, 1988). Using medical rehousing to this end does appear to work. It has the potential therefore to be harnessed to some of the aims of community care by ensuring that people with health needs are better placed to benefit from informal social support networks. This is not the only way of mobilizing appropriate support networks, but it does provide the flexibility needed to accommodate the diverse housing and care needs among populations whose individuals are too-often treated as a single client group (Clapham and Smith, 1990). As Elliott *et al.* (1990) observe '...specific living situations are suited to the needs of particular individuals while being inappropriate for others...this makes the case for a range of housing options' (p. 101).

Table 3. Rehousing and access to health care

Facility	Proportion who say access improved	
	Medical movers% (/349)	Other movers% (/190)
Family practitioner	36	33
Hospital	23	23
Close relatives	32	23**
Informal support networks	38	17**

**Differences between medical priority and other movers are statistically significant $p < 0.05$.
Other movers are those who have moved within the last 5 years and were interviewed either because they are trying to move again by using the medical priority channel, or because they failed to secure medical priority but moved anyway.

Table 4. Perceived quality of neighbourhood life following rehousing

Characteristic	Comparison between current and previous neighbourhood of residence. Current neighbourhood is: Better		Worse		Same	
	n	%	n	%	n	%
Overall quality of life						
Medical movers	288	83	19	5	41	12
Other movers	60	32	81	43	40	21
Suitability for household needs						
Medical movers	284	81	21	6	42	12
Other movers	53	28	84	44	40	21
Sense of safety and security						
Medical movers	219	63	54	16	72	21
Other movers	49	26	83	44	50	26
Sense of community spirit						
Medical movers	150	43	49	14	126	36
Other movers	34	18	66	35	71	37

The table contains row percentages where: $n = 349$ for medical priority movers, $n = 190$ for other recent movers (those who have moved within the last 5 years). Where rows do not sum to 100%, the differences is accounted for by those who answered 'don't know'.

All differences between medical and other movers are significant, $p < 0.05$.

Residential mobility and the quality of life

A third way in which the achievements of medical priority may be judged relates to its potential to enhance movers' quality of life. Many people have health problems which cannot be cured by rehousing but whose adverse consequences might be better managed in a different living environment. Surprisingly, only 15% of English local authorities view quality of life gains as very important in their decision to award or deny medical priority. Nevertheless, the tenants' and applicants' survey indicates that medical priority movers do attain homes better suited to people with health problems and disabilities, with a wider range of facilities, than do those who qualify for medical priority but are still waiting to move. Fifteen percent of movers (53/349) compared with 10% (18/189) of 'waiters' have wheelchair access; the figure for grab rails and alarm systems are 26% compared with 16%, and 22% compared with 5%, respectively. Movers are also more likely to have central heating (64% vs. 41%). These differences are all statistically significant ($p < .05$), and they are most marked in the one local authority (the northern case study) where all medical applicants receive a home visit from a multi-disciplinary assessment team. There are, then, some notable differences in the kinds of dwelling occupied by those rehoused on medical grounds when compared with those whose health is sufficient to merit a move, but who have not yet received or accepted an offer. These differences, moreover, are of a kind likely to enhance the quality of life, if not the general health, of those who have moved.

Almost anyone who moves home is also likely to experience a change of neighbourhood environment. Neighbourhood character is generally seen as an important component of personal well-being. Table 4 shows some ways in which recent movers perceive the quality of their neighbourhood life to have changed following rehousing. Notably people rehoused on health grounds are much more likely than other recent movers to feel their situation has improved. Four-fifths of medical priority movers but less than one third of other recent movers say their overall quality of life has been enhanced. Further, the latter group tend more often to experience a drop in quality of life after relocating. The discrepancy is even more marked with respect to the two groups' assessments of how well their new homes suit their households' needs. Medical movers are also two-and-a-half times more likely than other movers to feel safer and more secure in their present home, and to experience a better sense of community spirit than before (possibly reflecting their enhanced access to social support networks).

Overall, more than 80% of those rehoused through the medical priority system say they now live in a neighbourhood better suited to their households needs, and where the overall quality of life is better, than previously. Less than one third of other movers share these views. Moreover, full 71% (249/349) of medical priority movers say they are now happy and contented most or all of the time, compared with one in five (41/190, 22%) other movers.

Table five compares the quality of life—as measured by the Nottingham Health Profile—among those who have been rehoused as a consequence of a medical priority rating and those who have recently moved without such a rating. Medical movers have lower mean scores (indica

Table 5. Nottingham Health Profile mean scores for different groups of medical priority applicants[1]

	Energy	Pain	Emotion	Sleep	Social isolation	Physical mobility
Medical movers						
All ($n = 288$)	**44.8**	**30.6**	**26.2**	**39.2**	**21.2**	**31.8***
< 35	31.2	12.6	27.3	23.3	16.9	12.4
> 65	51.9	35.1	24.7	45.9	22.6	47.4*
Other movers						
All ($n = 145$)	**63.2**	**37.4**	**55.1**	**55.1**	**36.2**	**31.2***
< 35	57.6	27.3	53.1	58.7	35.6	21.9
> 65	79.5	45.2	57.3	51.5	38.8	46.1*
Awarded MP, but not moved ($n = 148$)	**63.4**	**44.4**	**44.5**	**52.2**	**31.1**	**39.7**
Denied MP, and not moved ($n = 88$)	**57.2**	**35.2**	**48.6**	**53.5**	**32.0**	**23.8**

*Indicates the only entries where differences between medical priority and other movers are *not* significant at $p < 0.05$.
Base numbers refer to those in each subgroup who answered the NHP section (excluding children and proxy interviewees).

ing less experience of stress) on all the dimensions of the profile except physical mobility, even controlling for age. This suggests that medical priority movers find their relocation advantageous, and therefore much less stressful than those who are equally keen to move to secure health gains, but whose relocation is secured outside the MPR procedures.

The survey suggests that MPR secures improvements in the quality of life which my be as important for securing health gains (indirectly) as are the direct effects of healthier homes. Cole and Farries (1986) also found that even where MPR fails to secure an overall improvement in health, it may alleviate the effects of disability and so help develop a sense of well-being. This perspective on the therapeutic effects of residential mobility provides the kind of bridge between geographies of disease and geographies of health that Kearns (1993) advocates.

Miracle...?

Even though the majority of MPR applicants see themselves as being forced to move, medical rehousing appears to be associated with an enhanced quality of life for people with health problems and mobility difficulties. The same strategy may help alleviate symptoms and improve access to care where this is required. The survey of tenants and applicants in three English cities suggests that, from the perspective of its users, medical rehousing acts as an effective health intervention. Residential relocation is obviously not a strategy appropriate to all sick people, and staying put may become more viable as measures for extending community care are put into place, and as the concept of 'lifetime housing' gains currency. However, for some people with health and mobility needs, MPR could be construed as a 'miracle': it harnesses a potentially stressful enforced upheaval to a therapeutic housing outcome.

The reason that rehousing sometimes 'works' as a health intervention is that social housing is, theoretically at least, allocated according to need rather than ability to pay. Social housing caters to people whose incomes cannot compete in the market, or whose needs create a demand for commercially unviable dwelling designs, adaptations or packages of care. Within the social sector, moreover, people with health problems and mobility needs occupy a privileged position relative to many other needs groups. The favourable outcomes this produces are secured in three ways. The first is a consequence of how medical priority is ranked against other priority claims to the subsidized rental stock. Generally, in the English example, only homelessness is awarded greater priority than health needs in the housing queues (and the legislative mandate for this has been partly dismantled). Therefore, people with recognised health problems and disabilities—whether new applicants or existing tenants—are routinely placed higher in the housing queues than are the wide range of other needs groups that housing allocations systems now service (Smith *et al.*, 1993; Smith and Mallinson, 1997).

The second set of mechanisms securing relatively favourable outcomes for medical priority applicants are the procedures which housing managers use—when people reach the top of the housing queue—to match priority applicants to the available housing stock. The effect of these procedures in most local authorities is to remove competition between homeless and medical priority applicants for the better parts of the housing stock (Smith, 1993). As a consequence of these procedures—which sometimes include formal or informal rules ensuring that only upper floor flats in certain locations are offered to people on the homeless list—homeless people are routinely directed into the worst parts of the public rented stock, often on difficult to let estates. Medical priority applicants on the other hand have access to

the full range of the local authority stock, and allocations officers are often required to follow prompts from health advisers relating to the appropriate floor level, space requirements, access and adaptation needs of the applicant.

Finally, once they receive priority status, medical applicants accrue considerable bargaining power: to a large extent they can negotiate to occupy the most desirable homes Allocations officers are under pressure to let vacant properties quickly and to minimize voids, and this impacts on many of their allocations decisions. For instance, it can tend to prioritize transfer tenants over waiting list applicants, as the former make their way up the council renting hierarchy and the latter come in at the bottom. Medical applicants from either list however have considerable leeway to refuse unsuitable offers and they can often make claims relating to dwelling type and area. From a housing management perspective, therefore, it makes sense to offer the pick of the stock to this group in the first place, rather than to make a less appealing offer and risk having it turned down.

Favourable housing outcomes accrue to medical priority applicants in a variety of ways: some are deliberately built into the allocations system; the others arise inadvertently as a range of bureaucratic rules and procedures are implemented. The consequence is that those who receive sufficient medical priority to secure rehousing have a good chance of ending up in properties which meet their physical and emotional needs.

Or mirage?

There is, nevertheless, a crucial problem with the operation of these 'miraculous' procedures: they may work, but they are in scarce supply. The favourable outcomes noted above are not universally available even to the population of people with serious housing-related health needs. Two surveys of housing managers show not only that applications for MPR are on the increase, but also that the extent of demand now outstrips the supply of suitable accommodation in over two-thirds of local authorities and three-quarters of housing associations (Smith and Mallinson, 1997). It is hardly surprising, therefore, that a relatively small proportion of applicants with health and mobility needs secures priority in the housing queues. Most studies indicate that only 5–10% of housing offers are made through medical priority queues, and that 20–30% of those applying for medical priority have their application turned down (Smith, 1990). Prescott-Clarke *et al.* (1988) found that one quarter of local authority waiting list applicants wanted to move for health reasons, but that only 8% believed this had been taken into account by housing managers. In our own study, two thirds of local authorities with figures available allocated less than 20% of their housing queues to people with medical priority.

In a system allocating goods according to need rather than ability to pay, it will always be the case that demand to some extent outstrips supply. However, the mismatch in the British public sector has been compounded in recent years by trends which, as Kearns (1995) observes, are 'beginning to stir the waters of formerly well defined routes of enquiry' within medical geography (p. 251). Kearns refers to the forces of economic and welfare restructuring which are shifting the underlying principles of service provision from equity to efficiency. This is manifest in the British housing system in the following ways.

First, a large proportion of the council rented stock has been sold to the private sector, and not replaced (Forrest and Murie, 1988; Cole and Furbey, 1994; Hoggart, 1995). During the 1980s more than one in five English council homes were sold to tenants, and by the mid-1980s, council sales were exceeding public sector newbuild by seven to one (Morris and Winn, 1990). In 1979, nearly one in three (32%) households rented from their local authority, but today the figure is less than one in four (24%). As housing spearheaded the shift from the state to the market in British public policy, the subsidy to the public sector halved and the subsidy to owner occupation (through tax relief on mortgage interest) doubled (Forrest and Murie 1989). The supply of progressively subsidized accommodation diminished, and the language of housing policy shifted from the concept of need (which fostered the development of MPR) to the notion of affordability (Whitehead, 1991). The scope for finding any space—let alone a healthy place—in the social rented sector suddenly narrowed.

Second, the dwellings sold by local authorities were purchased selectively, leaving a 'residual' public sector dominated by flatted estates in inner urban locations, containing the 'unhealthiest' homes in poorest repair (Flynn, 1988; Willmot and Murie, 1989). Thus it is that Roden (1995) documents a close spatial relationship between material deprivation and local authority housing on an enumeration district by enumeration district basis, in our three case study local authorities. He suggests too that, irrespective of medical priority status, the surveyed households may be living in more deprived neighbourhoods than average for the local authority district. In these circumstances rehousing into the public sector has growing potential to be a hazardous rather than a therapeutic experience (Smith, 1990).

Third, changes in the labour market and in income distributions mean that there is a growing benefit-dependent poor in the UK whose only real housing option is the public sector. Public housing disproportionately took the strain of unprece

sented restraint on the public sector borrowing requirement (Wilcox, 1993), and the result is an affordability gap between what people need and what the market can offer (Bramley, 1994). Public renting is therefore becoming the welfare arm of the housing system at a time when the character of the remaining stock makes it least suited to this role (Clapham *et al.*, 1990). In Britain, as in the USA, housing policy is increasingly divorced from the aims of social policy, and housing interventions have diminishing scope to service health needs (Howell, 1991).

One consequence of all these changes is that the amount of social rented housing available for MPR applicants and suited to their needs has shrunk, reflecting not only the smaller size and reduced quality of the social rented stock, but also the growing pressure on that stock from other priority groups. Previous studies of resource rationing have illuminated the inequalities that can arise in housing allocations systems when demand greatly exceeds supply (Henderson and Karn, 1984; Jeffers and Hoggett, 1995). The applicants survey which forms the basis of this paper taps into some of these.

The survey shows, first, that information about the existence of medical priority is often restricted. At least one of our local authority case studies revealed this to be a deliberate strategy implemented to ration the service. Accordingly, most applicants learn about the system from health professionals rather than housing officers. This is as true for transfer tenants as for waiting list applicants, which is perhaps surprising given the generally accepted view that, for rehousing more generally, the former gain an advantage over the latter by virtue of their greater knowledge of how the system works. In the case of medical priority rehousing however, only 14 respondents (less than 2% of the total) noticed any information about medical priority on their housing application form, and just 17% found out about medical priority from other information supplied by the housing department. Whether they are waiting list or transfer applicants, most found out about MPR through their existing contacts with the health and social services. In one sense, of course, this is encouraging: it indicates that the health services are able to mobilize the housing services to meet specific health needs. However, it also means that access to medical rehousing may reproduce the inequalities in access to care which have been shown to exist in other service areas, and that as a housing service, medical priority may not be equally available to all applicants.

Second, while most applicants who enter the needs assessment procedures find them easy to follow, a significant minority (240/836, 29%) feel the procedures are not exhaustive enough, and two in five say the information they judged most important was, in practice, overlooked. Again, transfer tenants have no advantage over new applicants at this stage: while 34% of the latter say help (from the housing department) is on hand when required, only 3% of the transfer tenants agree. People disadvantaged, and perhaps discouraged at this stage, include one in four (240/836) applicants who were given insufficient opportunities to make their needs known, one in three (248/836) who needed help with their application but could not obtain it, 8% who found the forms difficult to understand, and 10% who felt disadvantaged by their lack of aptitude with documents or their inability to concentrate. Predictably, dissatisfaction with MPR is most widespread amongst those denied a priority grading (and it is more marked in the south than in the north). Nearly 60% (320/538) of those awarded priority are satisfied with the way the local authority handled their application. Only 18% (23/127) of those denied priority agree. Even so, these findings signal at best a communications problem between housing departments and applicants, and at worst they imply that the organization of the applications procedures is insensitive to some households' needs.

The first two methods of rationing MPR are based on withholding information or expertise to parts of the target population. This kind of rationing is not designed to target the service towards those who need it most. It serves simply to reduce demand across the board. A third means of rationing *is* based on health selectivity, but of a type which is hard to justify. The survey indicates that people with physical health problems are more readily accommodated in the MPR procedures than those with mental health problems. The former group are dealt with more readily, and have a higher 'success rate' (i.e. are more likely to receive priority) than people with mental health problems. The latter group are under-represented among those awarded medical priority by 4 or 5%, whereas those with walking or vision disabilities are over-represented by 5 to 10%.

This discrepancy in the treatment of physical and mental health problems might be justified on the grounds that medical priority is most suited to helping the former group. People with mobility and vision difficulties often require ground-floor and/or adapted accommodation in order to live independent lives. Conceptually, and therefore managerially, a request to make this type of move is fairly straightforward. However, both our research and that of others (Elton and Packer, 1987) indicates that, often, the most notable health gains come from rehousing people with mental health problems. The case study phase of our research, moreover, confirms that the discrepancy in treatment between these two groups is more than a straightforward judgement about the

greater relevance of housing solutions to certain health problems. Housing managers evince concerns about the character and reliability of applicants with mental health problems and about their likely acceptability as neighbours to other tenants. Accordingly, people with mental health problems appear to be required to submit more forms, follow more procedures, and attend more interviews than other applicants, and they are more likely to be viewed as problem cases. Our conclusion, in the light of this, is that MPR is rationed by discretionary decision-taking which can work against the interests of people with mental health problems because it is geared to short term management priorities rather than to more enduring principles of social justice (Smith and Mallinson, 1996).

It is interesting to note that, apart from the differential treatment of physical and mental health problems, there are few health factors which distinguish between those awarded and those denied a priority grading. In fact, many of those who try, but fail, to secure medical priority experience their health problems as acutely as those who request and are awarded priority status. For instance, among rehousing applicants who have not yet moved, those denied medical priority have similar scores to those awarded it on the sleep and social isolation dimensions of the Nottingham Health Profile, and they fare worse on the emotion dimension (see Table 5). They fare better on energy, pain and physical mobility, but when compared with those rehoused under medical priority, people denied priority score notably worse on every dimension except physical mobility. It might, of course, be that those denied priority, unlike those awarded it, have a mix of conditions which rehousing could not help. Unfortunately it is hard to assess this from the survey because nearly half those denied priority (53/127) were not told why. Just 16% were informed that their health needs are not housing-relevant, though a further 25% learned that they were not sick enough to be considered.

A fourth means of rationing medical priority interacts with the range of other housing needs a particular applicant has. The data show that people who have housing needs arising from circumstances other than their health problems are over-represented among those denied specifically medical priority. People who claim housing priority on the grounds of overcrowding, substandard accommodation, homelessness or vulnerability *in addition* to poor health have a 12% greater likelihood of being turned down for a priority grading than their counterparts whose *only* priority claim relates to health needs. This discrepancy is especially notable among transfer tenants who are twice as likely to be denied medical priority if they have other housing needs. The reason for this is that, given the limited supply of healthy housing stock, housing managers effectively 'reserve' medical priority gradings for those who have no other route into the rehousing process. Medical priority operates, therefore, as if health needs are something experienced apart from, rather than in addition to, other housing needs (especially for transfer tenants, who tend more generally to have an advantage in other parts of the housing queue). This practice does expand the local housing system's total capacity to accommodate people with health problems, but it means that access to the best stock, which is routinely reserved for medical movers, is ultimately determined neither by the severity of applicants' health needs, nor by the totality of their housing need. In fact, it appears that the pick of the stock is reserved for those who only have health needs, even if this means that some people with worse health problems end up with less housing choice, simply because they happen to qualify for rehousing via a different route. This is particularly problematic for homeless people (Smith, 1993). The effect is that concerns associated with the rationing of a limited stock, rather than a consistent measure of health needs, have the last say in who is awarded or denied a priority rating.

A final element of rationing is introduced once medical priority is secured, and it affects the pace at which priority places in the housing system are occupied. The effect is that applicants can find it difficult to translate a priority grading into an acceptable housing outcome. Although, as we have seen, many of those who secure a medical priority move experience substantial improvements in their living space, this frequently comes at a cost. One cost is having to wait: the time lapse between gaining priority and receiving an offer of rehousing exceeded three months for 48% of priority households, and took over a year in 13% of cases. Even then many households could not move. Of the 452 respondents awarded medical priority, nearly half (213, 47%) turned down their first offer of rehousing, either because of the poor condition of the property (64/213, 30%) or because of its floor level (52/213, 25%), or because of its location in an unsuitable or disreputable area (83/213, 39%). This is despite the fact that, from a housing management perspective, these first offers might well have been the best of the available stock. Because the procedure is so constrained by supply issues, overall, the key factor affecting the speed of the application—the waiting time for receiving offers and for actually moving—is not health status but rather place of residence (a reflection of local differences in housing management and housing supply).

Another cost is having to trade-off the suitability of a particular dwelling against the character of a neighborhood. People desperate to move have no

option but to accept their first offer of rehousing even if it does not quite match their needs. Roden's (1995) analysis suggests that this group of applicants often do move into better homes and better neighbourhoods, but he points out that, in two of the three case study authorities, these homes tend nevertheless to be in the most deprived parts of the local housing stock. Those able to wait for a more suitable offer fare better in absolute terms than those who move at the first opportunity, but they may still have to move into more deprived neighbourhoods than before if they are to secure homes suited to their needs.

It appears, then, that medical rehousing is something more than a mirage, but rather less than a miracle. In a society which assigns a social role to (some) housing interventions, these interventions can, in theory and in practice, be a way of mediating health inequalities. Housing may, in the language of Britain's rapidly changing public health policy, form part of a potentially effective 'healthy alliance' (Smith *et al.*, 1994). The relevance and success of this alliance is, however, directly dependent on the extent to which housing policy, which has recently been pre-occupied with extending the right to wealth, is in future also designed to preserve a right to health.

Acknowledgements

This paper is one of a series arising from a study of housing provision for people with health and mobility needs based at the University of Edinburgh, directed by Susan Smith, and supported by the Joseph Rowntree Foundation. The authors are grateful to the other members of the project team—Sara Mallinson, Ann McGuckin and Christine Walker—and to the project's stimulating and uncompromising advisory group.

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